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Summer 2026 | Issue 17

In this issue:

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Contents

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- Issues affecting medicines optimisation and the supply of medicines
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Do you have an idea for an article or an area that you think we ought to be covering in the Journal?

If you have an idea for an article that you would like to discuss then please get in touch to see if we can include it in the Journal.

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Please contact me with ideas at:

John Chater, Editor – PM Healthcare Journal E: editor@pmpublications.co.uk

Editorial

At the time of publishing, we have a new Prime Minister, Andy Burnham, though so newly minted that he has yet to make any announcements as to the future direction of the NHS. He has, though, appointed a new Health Minister – Yvette Cooper – who replaces Jim Murray (himself only in post for three months).

In his first address as PM, outside No. 10 Downing Street, he pledged to expand mental health support to help more young people into work and, in a recent interview with *The Times*, that he would set out a '10-year plan' for the country. We now await further details of what these proposals will mean for healthcare and, more specifically, pharmacy.

For this summer issue of the *Journal,* we have a strong focus on mental health and workforce issues affecting the pharmacy sector.

Our opening article, sponsored by Viatris, explores the potential benefits of providing a lipid testing service alongside blood pressure checks in community pharmacy.

Anthony Young examines the barriers to pharmacy playing a greater role in mental health care within an integrated care system and considers how these can be overcome.

Rebecca Gossage-Worrall et al. evaluate an NHS England pilot examining the feasibility and acceptability of delivering antidepressant medication support through community pharmacies in England as part of the NHS New Medicine Service.

In our workforce section, Farzana Mohammed considers the hidden barriers to inclusion that may exist within pharmacy foundation programmes, while Rachael Lemon continues her series of articles, in this issue sharing insights into building trauma-informed teams across pharmacy.

As ever, our aim is to provide you with insights that translate into examples of best practice and real-world experience. If you have an idea for an article that you would like to share, we would be delighted to hear from you.

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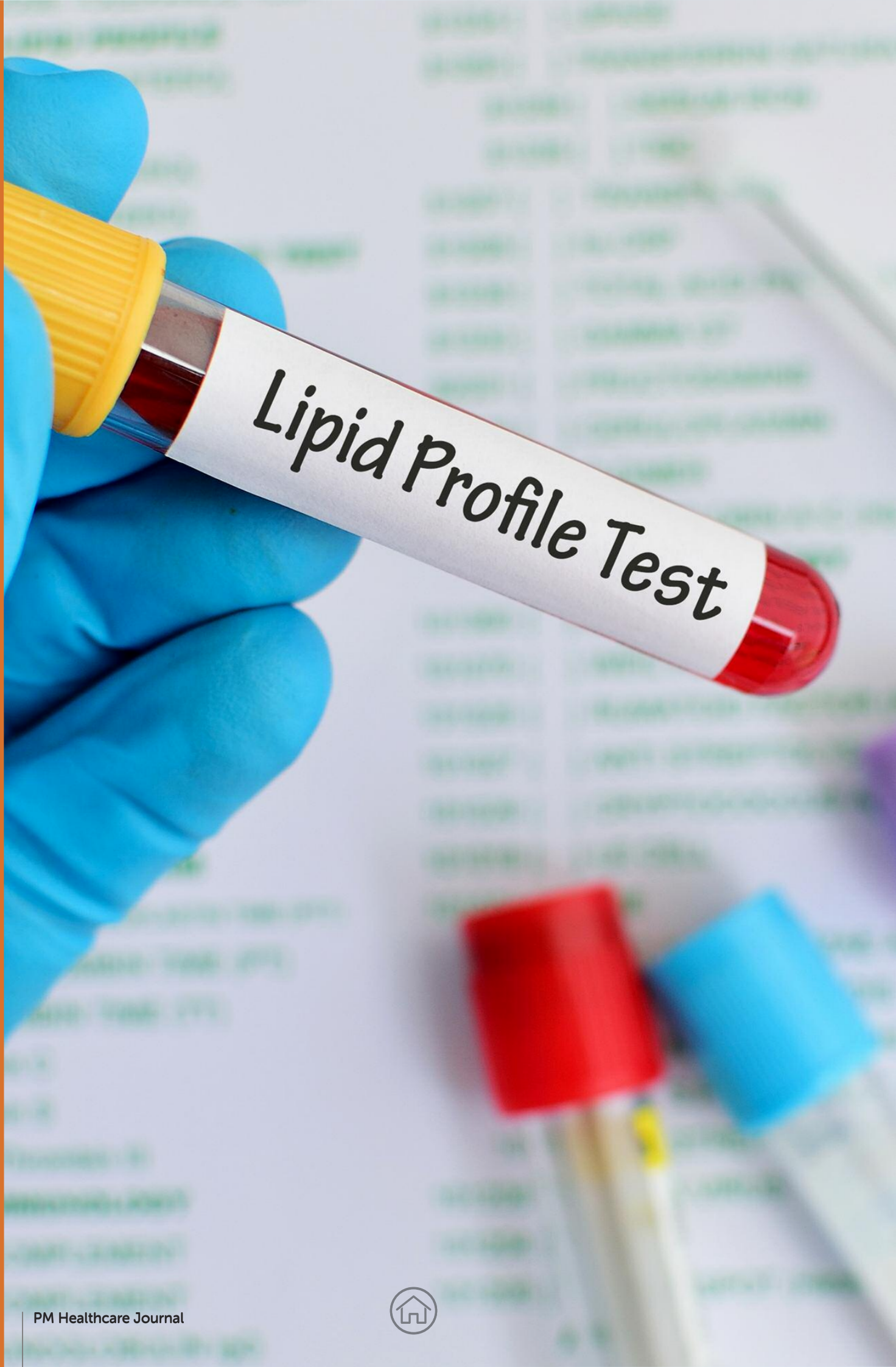
Lipid Profile Test

What could be the benefits of adding lipid testing to the blood pressure check service in community pharmacy?

An exploratory pilot to gather insights as to whether point of care lipid diagnostics in community pharmacies can optimise and evolve existing blood pressure services while improving time efficiency for both patients and pharmacists.

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Pilot organised and sponsored by Viatris medical affairs. Tests supplied free of charge by PocDoc. Tests ran in partnership with Burdon Pharmacies.

Introduction

Cardiovascular diseases (CVDs) remain among the leading causes of morbidity and mortality in England, a trend which is echoed both nationally and globally. CVD is the leading cause of death worldwide, accounting for 17.9 million deaths each year, 31% of all global deaths. (Public Health England, 2019).[1] High blood pressure (hypertension) and dyslipidaemia are principal modifiable risk factors contributing to increased cardiovascular risk (Cardiovascular disease risk assessment and prevention).[2]

Community pharmacies are a highly accessible setting for health-screening services that lower barriers to detection and management of these conditions (NHS England, Pharmacy Quality Scheme).[3]

Integrating lipid testing with blood-pressure checks using a point-of care testing (POCT) device such as PocDoc[4] may offer a valuable opportunity to improve early diagnosis, reduce multiple CVD risk factors, increase patient engagement and achieve better health outcomes.

The blood pressure check service (Hypertension Case-Finding Service)[5] was introduced to identify and where necessary treat adults living with high blood pressure, many of whom may be unaware of their condition.

CVD is multifactorial and individuals with it may have a multitude of comorbidities including, for example, raised blood pressure and high cholesterol. In 2022, 53% of adults in England had raised cholesterol (i.e., ≥ 5mmol/L) with a higher prevalence among women (56%) than men (49%). (Health Survey for England, 2022 Part 2, Official statistics).[6] And in a UK-wide screening of 227,592 volunteers, 54% had high total cholesterol and 27% had high blood pressure (Our Future Health).[7]

> **"These data emphasise the large unmet need for identification of dyslipidaemia in the adult population, which supports the rationale for pharmacy-based lipid screening."**

In addition, medicines adherence can be problematic within this patient group, as many patients are asymptomatic. Factors in nonadherence may also include a lack of understanding of symptoms and potential outcomes leading to low motivation to adhere to treatment.

Supporting patients to understand the multiple changes needed to improve their overall heart health may also mitigate against the significantly elevated risk of adverse clinical outcomes for patients with CVD due to persistent nonadherence. (PMC PubMed Central)[8]

By diagnosing more than one condition at a time, the pharmacist can help improve the patients' health literacy to cardiovascular disease as a whole rather than a condition-by-condition approach and hopefully start management earlier within the disease progression journey.

Supporting NHS Plan objectives through improved local testing

The NHS Plan, *Fit for the future: 10 Year Health Plan for England,*[9] (July 2025) prioritises three key focal points for the achievement of its objectives:

1. Hospital to community – Bringing care closer to where people live, outside of secondary care. Neighbourhood health centres will be created in every community ('a one stop shop for patient care') and the role of community pharmacy will be increased in the management of long-term conditions.

2. Analogue to digital - New technologies and digital approaches to modernise the NHS. The enhanced NHS App will be a 'full front door' to the entire NHS, including booking tests, managing medicines, long-term conditions and uploading health data.

3. From sickness to prevention – Focusing on causes rather than treatment. Shortening the amount of time people spend in ill-health by preventing illnesses before they happen – 'harnessing a huge cross-societal energy on prevention'.

The role of community pharmacies in providing local health-screening services through POCT, supported by improved digital technologies (e.g., access to patient records), and contributing to the objective of prevention through healthcare management and lifestyle modifications is strongly evident and aligns closely with the above-cited general objectives of the NHS Plan.

PocDoc: Point-of-Care Lipid Testing Technology

The PocDoc Pro Lipid test is a UK CA (UK Conformity Assessed) marked point-of-care device designed to measure a comprehensive lipid profile from a finger-prick blood sample including total cholesterol, LDL-C (Low-Density Lipoprotein), HDL-C (High-Density Lipoprotein), and triglycerides, with results available within minutes (POCDOC's GUIDE TO LIPIDS).[10]

A self-test 'Healthy Heart Check' is also available from PocDoc, via its interface app, which produces a patient and healthcare professional-friendly CVD report. PocDoc's home test Healthy Heart Check provides lipid results, an assessment of 'heart age' and a 10-year risk assessment of cardiovascular disease. (PocDoc)[4]

The device's ease of use, minimal sample requirement and rapid turnaround make it well suited for incorporation into pharmacy workflows alongside blood pressure measurement (What is PocDoc?)[11] Training protocols may include a one-

hour hands-on session followed by supervised practice in the pharmacy until staff demonstrate competency. The availability of self-test kits also extends the service beyond the pharmacy setting, enabling patients to monitor their lipid levels periodically between appointments. Regular self-testing may reinforce medicines adherence and support ongoing lifestyle interventions, while providing useful trend information that can be reviewed during pharmacy consultations.

Benefits of Adding Lipid Testing to Blood-Pressure Services

Enhancing Cardiovascular Risk Assessment

Simultaneous testing of blood pressure and lipid profile enables a comprehensive assessment of cardiovascular risk. Lipid profile could help to provide a more comprehensive assessment of cardiovascular risk due to testing for multiple CVD factors. (NICE, NG238).[12] Since hypertension and dyslipidaemia collectively increase CVD risk, early identification facilitates timely preventive intervention (Statins for the primary prevention of cardiovascular disease).[13]

In practice, pharmacy staff may adopt a risk calculator such as QRISK®3[14] to integrate lipid and blood-pressure data in making referral decisions. PocDoc allows for QRISK®3 calculation within its app and presents this data to patients in a health literacy friendly manner, by means of a heart health age.

Lipid results could be interpreted within the context of overall cardiovascular risk rather than as definitive measures in isolation. Cholesterol concentrations are subject to normal biological variation over time, and analytical factors may also contribute to differences between measurements. Consequently, a single lipid result provides a useful snapshot of cardiovascular risk factors but may not fully reflect an individual's longer-term lipid status. Repeated testing and assessment of trends can therefore provide a more reliable basis for clinical decision making. Risk-based approaches such as QRISK®3, which incorporate multiple variables rather than relying on a single lipid value, support a more comprehensive and clinically meaningful assessment of cardiovascular risk. (Cholesterol is a measurement, not a verdict).[15]

Improving Accessibility and Patient Outcomes

Pharmacies are accessible healthcare locations: 80% of England's population lives within a 20 minute walk of a pharmacy (Update on the Pharmacy First service).[16]

Adding lipid screening in this setting can reach underserved groups who may less frequently attend GP appointments (Health Profile for England: 2021).[17] Immediate availability of results deliverable through PocDoc, may enable 'on-the-spot' lifestyle advice and referral, promoting earlier diagnosis and management.

Evidence from screening programmes indicates that immediate feedback is associated with higher patient engagement and better adherence to follow-up. For instance, the Our Future Health data showed 54% were found to have high total cholesterol levels in large-scale screening, supporting the case for rapid feedback in community settings (Our Future Health).[7]

Reducing Healthcare System Burden

By diverting screening activities to pharmacies, pressure on general practice and secondary care can be alleviated, reserving those resources for acute and complex cases (Update on the Pharmacy First service).[16]

Early detection of risk factors may reduce future hospital admissions for cardiovascular events, providing long-term economic savings (Statins for the primary prevention of cardiovascular disease).[13]

Despite a number of blood pressure treatment options being available, problems such as patient adherence persist.

Additional factors to consider include:

- Availability of patient time (to understand and adapt to new treatment regimens)
- Patient motivation to change (e.g., understanding the benefits of doing so)
- The inefficiencies inherent in referring and diagnosing cardiometabolic conditions in isolation

If the patient is counselled on all modifiable cardiovascular risk factors which need to change,

they may have an added incentive to remain on treatment or adapt their lifestyle factors appropriately.

Community pharmacists often have well-established relationships with patients, which can help support patient engagement and receptiveness to lifestyle and treatment advice. This also helps with medication adherence.

As pharmacists are already able to identify high blood pressure, simultaneously highlighting other cardiovascular concerns e.g., lipids within the one consultation could save time overall, builds importance and improves patient perception.

Economic modelling suggests that shifting a portion of screening to pharmacy settings can generate efficiency gains in primary care workload and downstream cost avoidance, aligning with system-wide objectives of prevention and optimising resource utilisation.

Framework for Rollout Strategy

The successful implementation of lipid testing alongside blood-pressure screening in pharmacies requires a structured approach, including:

Stakeholder Engagement

Engage pharmacy staff, general practitioners, commissioners, and patients early to ensure acceptance and integration into care pathways (National Strategic Guidance for at Point of Need Testing).[18] For example, run focus groups with pharmacy teams and local GP networks to refine referral workflow, identify bottlenecks and establish data sharing agreements.

Training and Competency Development

Develop training modules covering device operation, interpretation of results, patient counselling, and referral criteria (NHS England).[3]

Module draft outline:

- Module 1: Device operation and workflow integration
- Module 2: Interpreting lipid results & cardiovascular risk (including QRISK3 usage)
- Module 3: Patient communication & lifestyle counselling (role-plays, motivational interviewing)

- Module 4: Referral pathways & follow-up documentation
- Module 5: Quality assurance & service audit

For reference, the Centre for Pharmacy Postgraduate Education (CPPE) offers an e-course Fundamentals of Cardiovascular Therapeutics[19] covering cholesterol and cardiovascular risk for pharmacy professionals.

Include refresher training annually and competency audits every 6-12 months to sustain service quality.

Quality Assurance and Governance

Introduce internal quality-control processes and external proficiency testing aligned with UK POCT guidelines to maintain accuracy and reliability (National Strategic Guidance for at Point of Need Testing).[18]

Data Management and Integration

Digital recording solutions may be implemented to securely capture test results and enable data sharing with primary care providers to improve continuity of care and audit processes.

> **"Consider integration with NHS Summary Care Records or local GP electronic patient records for seamless referral communication. Appropriate notes can also be shared electronically with the patient via the NHS app."**

In line with NHS Plan objectives (above) this form of testing (PocDoc) can be initiated in pharmacy, with the patient able to continue testing at home, monitoring lipids levels without the need for routine healthcare intervention. Self-monitoring at home allows patients not only the opportunity of taking control of their own healthcare but also provides ongoing and positive encouragement through awareness of real-time improvements.

Referral Protocols

Establish clear referral pathways for patients with abnormal lipid or blood-pressure results, integrating fast-track links to primary care or specialist clinics (NICE, 2019).7 E.g., patients with LDL-C > 4.0 mmol/L and one or more additional risk factors → referral to GP within 2 weeks.

Utilise new independent prescriber pharmacists to improve referral and prescribing pathways for patients identified at the pharmacy level.

Public Awareness Campaigns

Promote awareness through targeted communication to encourage uptake, particularly in high-risk and underserved populations (Health Profile for England: 2021).[17] For example: social media posts (pharmacy page), in-store posters, local GP network newsletters, community outreach events.

Patients may also be recruited through campaigns, allowing healthcare professionals to maintain a long-term relationship with patients who have identified themselves as being interested in or requiring specific testing or interventions.

Pilot and Evaluation

Run phased pilot projects to monitor service uptake, patient satisfaction, clinical outcomes, and operational feasibility; refine protocols prior to wider rollout (Cholesterol Point of Care Testing in community pharmacy).[20]

Set key performance indicators (KPIs): number of patients screened per pharmacy per month, % requiring referral, % attending follow-up, patient satisfaction score.

Economic Analysis

Cost Considerations

The addition of PocDoc testing involves direct costs including device procurement, consumables (test cartridges), staff training, and time spent conducting tests. Estimated costs per test range from £15 to £25 depending on volume discounts and consumable pricing (internal study). For example, assuming a pharmacy screens 50 patients/week → annual screening ~2,600 tests → annual cost ~£39,000–£65,000 inclusive of consumables/training.

Potential Savings

- **Reduced GP and Hospital Visits:** Early detection and management of dyslipidaemia and hypertension can prevent costly cardiovascular events such as myocardial infarction and stroke (Statins for the primary prevention of cardiovascular disease).[13]
- **Improved Health Outcomes:** Interventions leading to LDL-C reduction via lifestyle modification or statin therapy reduce long-term CVD risk and healthcare costs (NICE, NG 238).[12]
- **Efficiency Gains:** Shifting screening to pharmacies reduces GP-appointment demand,

enabling reallocation of primary-care resources to more complex patient needs (NHS England, Pharmacy Quality Scheme).[3]

Cost-Effectiveness Modelling

Indicative modelling suggests that combined blood pressure and PocDoc lipid testing may be cost-effective compared with usual care, generating incremental cost-effectiveness ratios (ICERs) within the range generally considered cost-effective by NICE (£20,000–£30,000 per quality-adjusted life year [QALY] gained) (Should NICE's cost-effectiveness thresholds change?)[21]

Sensitivity Analysis

Model results were sensitive to assumptions regarding patient adherence to referral and treatment recommendations. Broader health campaigns and pharmacist-led motivational interviewing may improve adherence, increasing cost-effectiveness. (For example, improving patient adherence to referral and treatment from 70% to 85% reduced the ICER by ~£1,500 per QALY in the sensitivity scenario.)

Evidence supports the assumption that pharmacy-based CVD screening is acceptable to the public and its uptake could be improved through increased awareness (A community pharmacy-based cardiovascular screening service).[22]

Case Study: North East London PocDoc Pilot Programme

A six-month pilot (three-month control with normal blood pressure check service, then three month including PocDoc and blood pressure service) involving 15 community pharmacies in North East London tested the feasibility and impact of combined blood pressure and PocDoc lipid testing (Cholesterol Point of Care Testing in community pharmacy).[20]

Sample size and gender

The table below shows the referral type to pharmacy split by gender. Although referral sources are relatively evenly distributed across the overall sample, differences emerge when examined by gender.

"Men are more likely to be referred by a GP (42% vs 29%), whereas women are more likely than men to self-refer (30% vs 22%). This suggests an association between gender and referral source."

Key findings of the pilot include:

- 87 screenings completed
- 28% new-diagnosis rate of elevated cholesterol levels requiring follow-up (Association between coexisting hypertension...)[23]
- Positive patient feedback emphasising convenience and immediacy of results
- Increased pharmacist confidence in providing cardiovascular-risk advice following training

This small-scale pilot provided an insight as to the benefit the addition of a cholesterol test within the blood pressure check service could have on identification alone, not to mention the downstream supposed benefits.

Patient referral Source (% in in parentheses)

Variable	GP Practice	Identified in the pharmacy	Self-referral	Total
Female	71 (29)	103 (41)	75 (30)	249 (100)
Male	51 (42)	43 (36)	27 (22)	121 (100)
Total	122 (33)	146 (39)	102 (28)	370 (100)

Conclusion

Integrating the PocDoc lipid test into routine blood-pressure checks in pharmacies across England presents a cost-effective, patient-centred approach to comprehensive cardiovascular risk assessment. It enhances early detection, empowers patients, supports primary-care services, and aligns with national public-health goals. A well-planned rollout strategy, incorporating training, quality assurance, data integration, and referral protocols, is essential to maximise benefits. Economic modelling supports the service's viability in contributing to reduced CVD burden and healthcare costs.

"Next steps should include a national phased rollout, further real-world evaluation of patient outcomes, and development of patient-facing materials (e.g., leaflet, digital app) to support the service."

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The barriers to pharmacy being more involved in mental health care within an Integrated Care System: cross-sectional survey study

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- Anthony Young (primary author) – Formulation of research question, design, data collection, analysis and report write up
- Martina Khundakar – Editing
- Laura Lindsey – Editing

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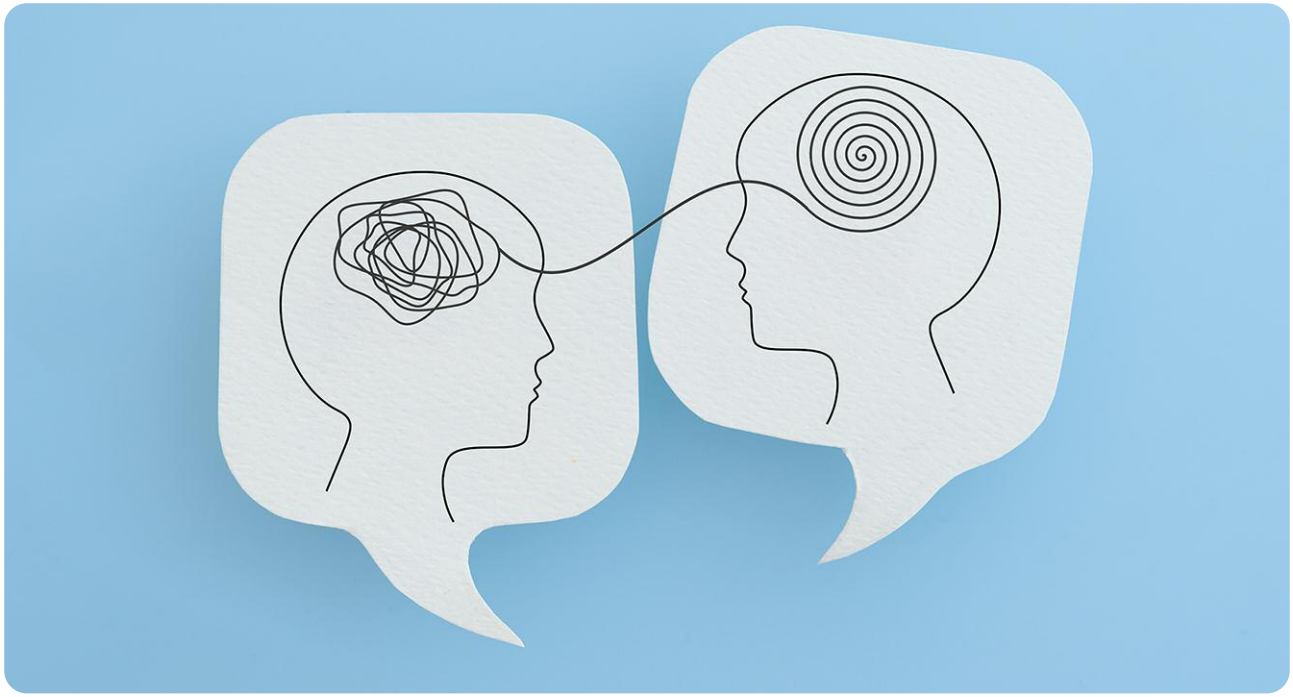
Abstract

Introduction: Parity of esteem, ensuring equal care for mental health patients as for those without mental health conditions, is crucial to reducing the mortality gap. Improved treatment concordance and early physical health interventions can alleviate system pressure, though targeted interventions may increase admissions. The pharmacy sector plays a key role, but challenges remain multifactorial.

Aim: This research aims to identify barriers within the ICS pharmacy workforce that limit its contribution to achieving parity of esteem to people with mental health conditions, and to explore how these barriers might be addressed.

Methods: A mixed-method questionnaire was distributed to the North East and North Cumbria ICS Pharmacy workforce in December 2021. The survey included quantitative and qualitative questions to gather comprehensive data. Ethics approval was obtained from the University of Sunderland.

Results: Out of 362 responses, 307 were from professionally registered staff. Key findings include moderate self-rated knowledge of mental health conditions, with time constraints, self confidence and lack of training opportunities as major barriers.



Discussion: Time constraints, diverse prior training, and moderate confidence levels were identified as barriers. Improved protected time for targeted training are recommended.

Conclusion: Addressing time constraints, enhancing training, and improving information sharing are critical to achieving parity of esteem in mental health care within the pharmacy sector. Strategic recommendations include stakeholder engagement and leveraging mental health champions to drive change.

Keywords:

- Parity of esteem
- Mental health care
- Pharmacy involvement
- Integrated Care System (ICS)
- Barriers to care
- Cross-sectional survey
- Treatment concordance
- Physical health interventions
- Pharmacy workforce
- Knowledge and training
- Confidence in mental health
- Stakeholder engagement
- Mental health champions

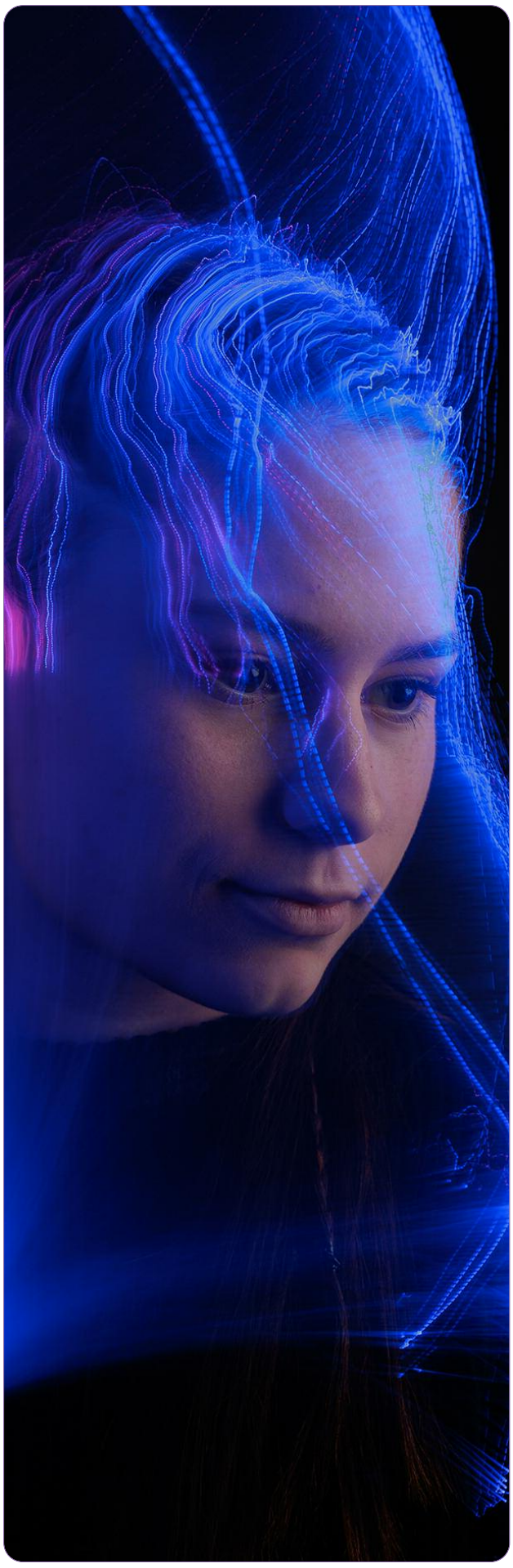
Impact statement

This study identifies critical barriers within the ICS Pharmacy workforce that hinder effective mental health care, emphasising the need for improved training, better access to patient information, and strategic stakeholder engagement. Addressing these issues is essential for achieving parity of esteem and enhancing patient outcomes in mental health services.

Introduction

One of the key enablers to improved care of mental health patients is parity of esteem[1] whereby patients with a mental health condition get the same level of care in all parts of the system as those without to reduce the mortality gap.[2] Pressure across the system could be reduced through improved concordance with treatment and earlier interventions in the physical health of patients,[3,4,5,6] although it could be argued that better care of physical health through targeted interventions may increase admissions.[7] The Pharmacy sector has a key role to play[8] although it can be argued that this is a multifactorial issue and one size does not fit all.[9]

Parity of esteem is a well-known factor in the mortality gap of 15-20 years in patients with a mental health disorder[4,10,1] although increased funding is not always the solution[11] and some argue that the term is a red herring, and the issue is



purely down to poor quality services.[12] Pharmacy support is an area of provision that has been shown to improve patient outcomes.[13,14,15] Knowledge of mental health conditions and treatment and signposting to information are areas where improvements in care and outcomes have been shown to be effective in systems.[16] Poor provision of services provided by pharmacists to patients living with a mental health condition has been well documented, where confidence and knowledge was a key contributing factor.[17,18,19,20]

Research has shown that limited education and training and low confidence in mental health prevents pharmacists delivering good mental health services in the community are.[21] Time to expand knowledge and to deliver services have been identified as barriers to effective interventions by pharmacists.[22] Time has been postulated as a key barrier to personal development in other fields such as engineering, veterinary medicine and amongst general managers[23,24,25] so clearly an important issue when it comes to development of services. High workforce confidence directly affects patient ratings in services[26] and services are better when delivered by a competent and confident workforce.[27] However, a balance must be struck as overconfidence can lead to a reduction in quality of services and organisational failure.[28,29] Workforce knowledge and skills are important determinants of service quality and patient outcomes and can also be the critical to future organisational success, an important factor when seeking organisational support for workforce development.[30,31]

Aim

The research aim is to identify what the barriers are within the ICS Pharmacy workforce to providing parity of esteem to patients with a mental health disorder and how these can be overcome. The research will focus on how parity of esteem affects outcomes the barriers to increased involvement of pharmacy in mental health services and how information sharing affects outcomes.

Ethics approval

This project received ethics approval from the University of Sunderland in November 2021.

Methods

3.1 Questionnaire design

A mixed method questionnaire was sent out to the North East and North Cumbria (NENC) Pharmacy ICS workforce by e-mail in December 2021. The questionnaire was piloted with a small group of pharmacy professionals to ensure clarity and comprehensiveness. The advantages of online surveys are low cost, ease of distribution to large samples and environmentally friendly, disadvantages include internet access and risk of loss in email inboxes.[32,33] Mixed method questionnaires comprise of a mixture of both quantitative and qualitative questions and may give better results than just using one method.[34,35] It allows for data rich responses to be received from complex systems, such as healthcare as neither, on their own, give a broad enough reach.[36] The survey included two open ended questions, and the other 10 questions were a mixture of yes/no, Likert scales[37] and multiple choice.

Consent was gained through a recognised manner by including an explicit request within the survey and stated how the data would be utilised to avoid any misconceptions.[32]

3.2 Population

The total estimated number of professionally registered staff in the pharmacy workforce was 3,849 in April 2021. This does not involve support staff and students. A snowballing technique, where existing networks within the ICS were used to distribute the survey, was used for recruitment.[38,32]

Results

A total of 362 responses were received. Out of this total response, 307 were received from professionally registered staff which is approximately 8% of the registered workforce, this resulted in a confidence level of 95% with a margin of error of 0.9%. There was an even spread of years post qualification. The sex of the responder was not required to complete the survey. The split of respondents per sector was as follows:

Category / Role	Percentage of Response
Hospital sector staff	41%
Primary Care Networks (PCNs)	22%
Community Pharmacy	15%
General Practice	14%
Clinical Commissioning Groups (CCGs)	13%

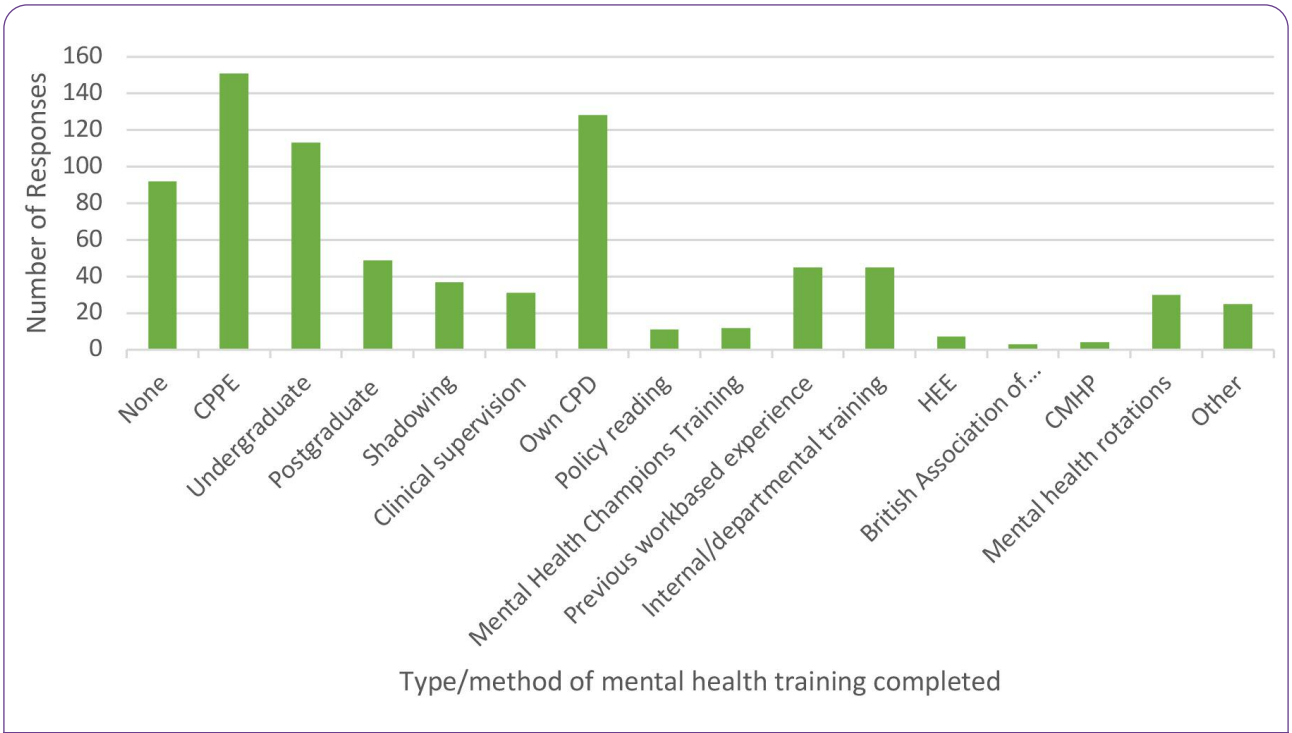


Figure 1. Type of mental health training completed by the responders

Some questions requested the responder to select all answers that applied to them so the number of responses may be greater than total number of respondents. 62% described their role as patient facing, which is important to note in the context of this work. The results are organised under three strategic themes which are: time, knowledge and confidence.

For 31% (n=113) of respondents the undergraduate curriculum was their source of prior mental health training (figure 1).

A quarter (n=92) of the respondents stated that they had not completed any mental health training, which will include some professionally registered staff. Centre for Pharmacy Postgraduate Education (n=151) and own CPD (n=128) were the most common sources of training. For self-rated level of knowledge on mental health conditions and medications the average rating was 3.16 out of five (1=low, 5=high) indicating moderate knowledge across the respondents. Of the respondents, 314 (87%) felt that advising on prescribing and associate monitoring in patients with mental health conditions was applicable to their role. The average confidence rating in undertaking this task was 2.73 out of 5. It is worth noting that respondents recognised that this aspect was important but confidence to deliver it was not high which could affect outcomes to patients or avoidance of the situation.

"Seeking support for mental health related queries from peers and colleagues as well as networks was the most used resource used by all respondents (67%, n=243) followed by online treatment guidance (57%, n=205). Third of the respondents (n=119) also used generic online searches (figure 2)."

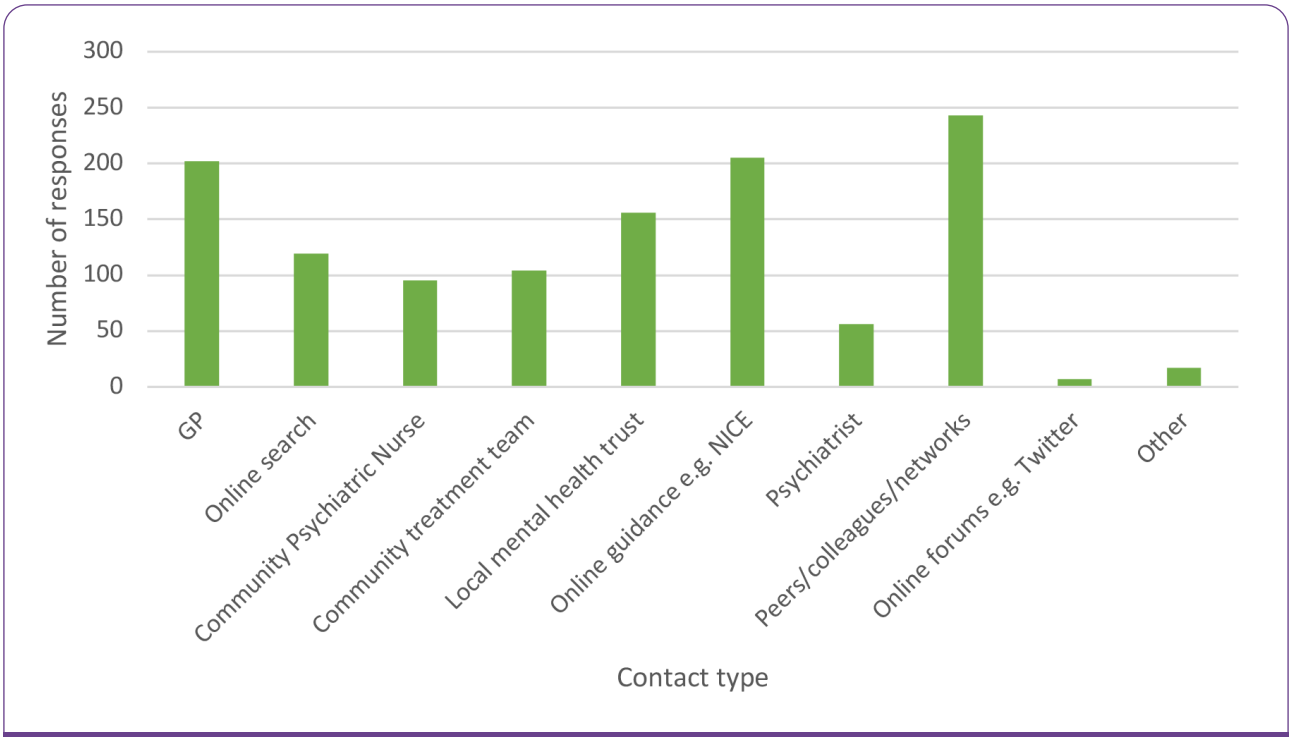
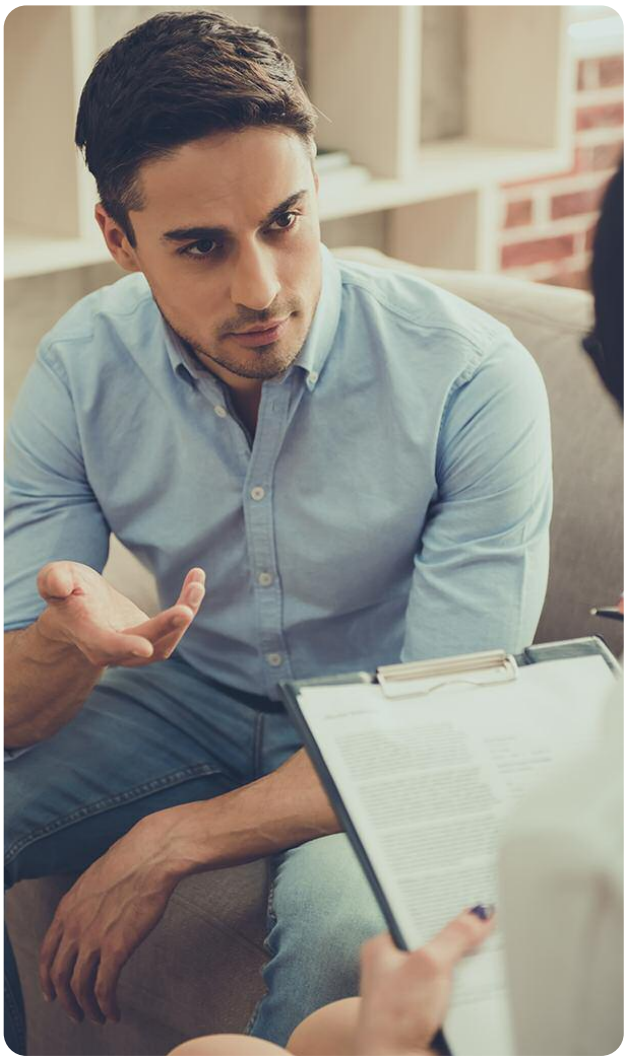


Figure 2. Contact for queries regarding mental health.

In terms of specific clinical professionals, GPs were most used point of contact (56%, n=202) followed by community psychiatrist nurse (27%, n=95), psychiatrists (15%, n=56) and the community treatment team being source of support with queries for 29% (n=104) respondents. The responses were not separated in the analysis by the location of the respondent, so it is not known whether this overall pattern was the same for the different locations of work.

Time to learn or perceived lack of time was a was cited by 41% of respondents in this study (n=234). The knowledge of existing opportunities (27%, n=155) and perceived lack of training opportunities (17%, n=98) for staff were other key barriers (figure 3). An open response question was available to allow other barriers to be shared, some responses included:

- Improved training promotion for existing courses to all sectors
- Protected time
- Improved access to online courses
- Condition specific training
- Improved access to patients' medical records/notes



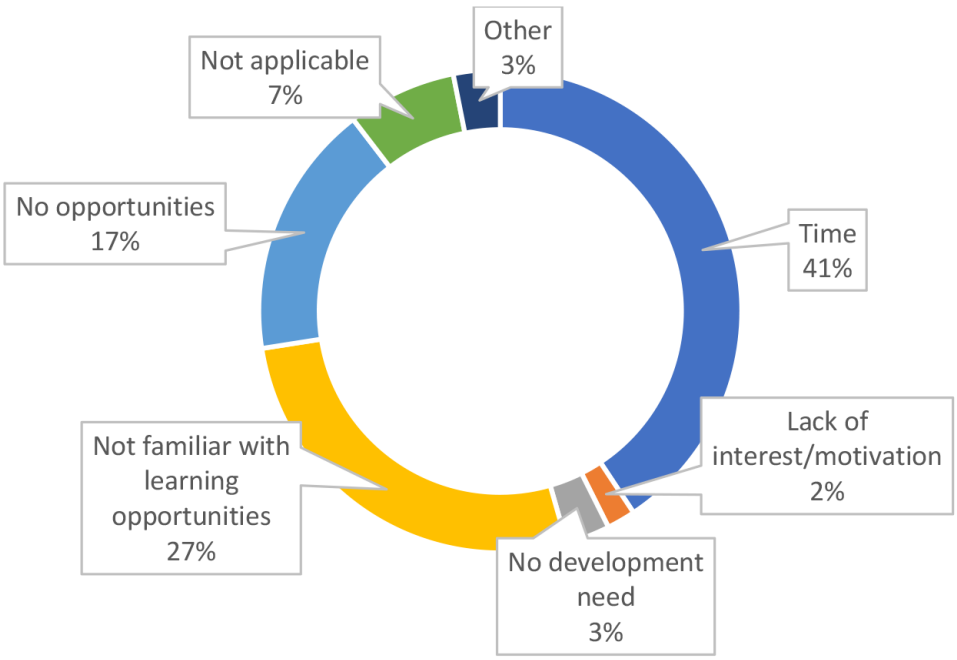


Figure 3. Barriers to you improving mental health knowledge

Discussion

This study aimed to identify the barriers within the ICS Pharmacy workforce to providing parity of esteem to patients with a mental health disorder and how these can be overcome..

Strategic theme 1 – Time

Time was given as the main barrier to development of knowledge in mental health given by respondents with 41%. Due to pharmacy and pharmacy staff being under pressure to deliver more frontline services,[39] especially during COVID19[40] with no significant investment and the literature supports this barrier being expressed.[22]

The difficulty with this barrier is that it is simply impossible to make more time in the day to deliver training so any recommendation must be innovative and engage the workforce, to enable its delivery. Good communication and appropriate use of technology can help share knowledge, support learning and spread good practice across the pharmacy workforce.[41]

Strategic theme 2 – Knowledge

A very diverse array of prior training was evident from responses with around a quarter stating that they had completed no training. Lack of undergraduate training in mental health is a key finding and one that needs to be addressed to ensure a competent workforce.[42] It has been shown that mental health conditions were broadly covered in all UK schools of pharmacy. However, this did not necessarily result in a more competent practitioners although the responders to this survey self-rated their knowledge as moderate.[43]

"Whilst knowledge of mental health conditions was moderate, knowledge of where to go for support and further information is excellent. while GPs were the most frequently cited source of support, future service models may benefit from strengthening access to multidisciplinary advice to reduce pressure on primary care services.[44,45]"

Lack of opportunities or knowledge of training provision for mental health was cited by 44% of respondents. This is an area that will need further exploration and will be covered within the recommendations as this survey did not allow for a more detailed response.

Strategic theme 3 – Confidence

Confidence levels in the respondents was average with a self-rating of 2.73 out of 5. A more surprising response was that 13% felt that it wasn't part of their role. However, this could be because they are non-professional support staff. Regardless, they can still have a role to play to support patients, an example being the delivery driver noticing the early signs that someone is becoming depressed by lack of self-care. Confidence is key to delivering safe and high-quality care.[46]

Limitations

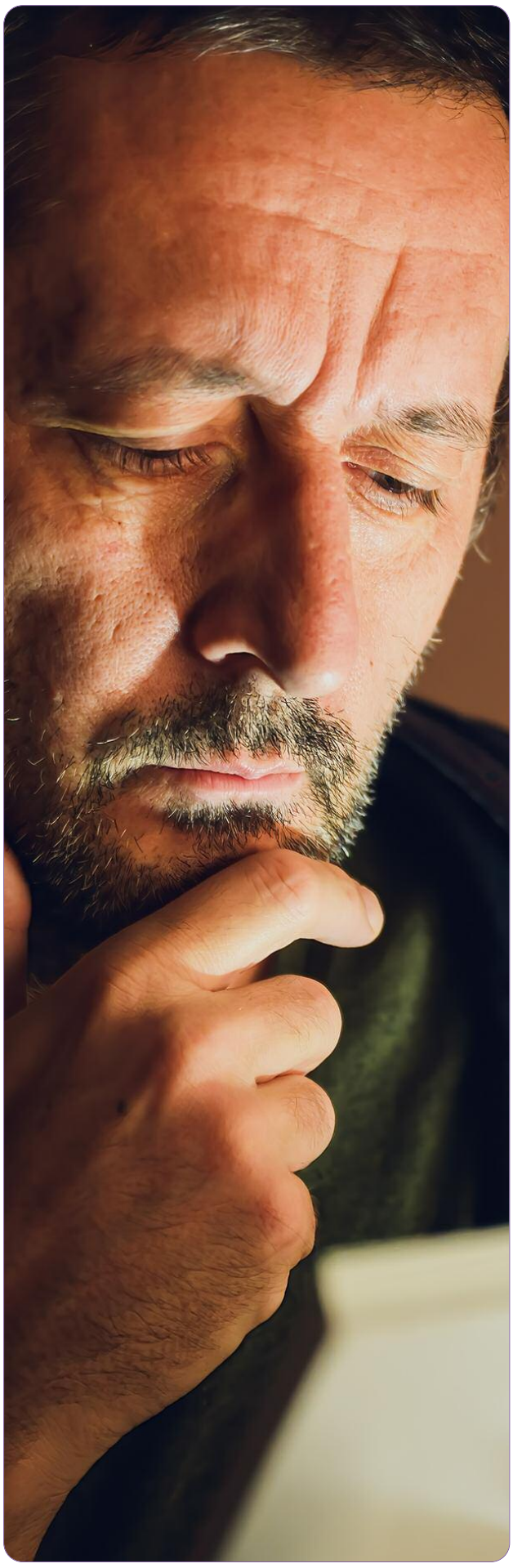
Snowball sampling can introduce bias as it will only gain responses from those within networks and engaged within the ICS and relies on that onward referral and engagement.[47] Any results from this sampling method would be generalisable to the wider ICS. It shows trends and opinions from within the ICS pharmacy workforce and these match those emerging

themes from the secondary research. The questionnaire was distributed via online links which has been attributed to age related bias,[48] however, this does not seem to be the case within this research as the split across age groups was even. The data has been critically analysed but has not been through qualitative analysis or coding which may influence conclusions.

Conclusion

This project sought to analyse what barriers exist to better mental healthcare provision by pharmacy within the NE and NC ICS. The secondary research themes were used to structure the primary research and to produce a robust set of actions recommendations:

Recommendation	Whom
1. Present results of survey to the ICS Workforce group to gain engagement and agreement to take forwards.	Researcher
2. Business case to create a project manager post to lead on implementation.	Researcher
3. Stakeholder engagement event to look at barriers and how to collaborate to overcome. (Themes 1, 2 and 3)	Project manager
4. Financial plan to model investment required to implement and support the project.	Researcher
5. Engage with local higher education institutes, recognised training organisations and mental health trusts to review current, undergraduate and postgraduate training for pharmacy professionals. (Theme 2 and 3)	Project manager and mental health trusts lead for training and education
6. Ensure that the ICS Workforce Strategy and that any future ICS Strategy includes this theme so that the vision is continued and further developed.	Project manager



The work found that the key emergent themes within the literature matched those within the ICS, found by a mixed method quantitative questionnaire using judgmental sampling. Three key barriers continue to limit pharmacy professionals' ability to improve mental health care for patients: lack of confidence, insufficient knowledge and skills, and limited time within clinical practice. Addressing these challenges requires a coordinated, system-wide approach spanning undergraduate education, postgraduate training, workplace development, and national policy. Suggested actions include embedding mental health competencies throughout pharmacy curricula, expanding structured postgraduate learning and supervision, protected time for training and patient-facing mental health interventions, and inclusion of mental health expectations within professional standards and workforce strategies. Without meaningful action at each level, pharmacy will be unable to fully contribute to achieving parity of esteem between physical and mental health, and opportunities to improve patient outcomes will continue to be missed.

Further research is needed to determine the most effective approaches for addressing the three key barriers of confidence, knowledge, and time across the pharmacy workforce. Longitudinal studies should evaluate whether enhanced undergraduate mental health curricula translate into sustained improvements in clinical practice following registration. Research is also required to assess the impact of postgraduate training programmes, mentoring, and supervised practice on pharmacists' confidence and competence in supporting people with mental health conditions.

At an organisational level, implementation research should explore workforce models, protected learning time, and service redesigns that enable pharmacy professionals to incorporate mental health care into routine practice. Economic evaluations would help demonstrate the costs and benefits of investing in pharmacy-based mental health interventions. Further work is also needed to understand the perspectives of patients, carers, and individuals with lived experience, ensuring that workforce development initiatives address patient needs and improve outcomes. Finally, national-level research

should examine the impact of policy, professional standards, and commissioning arrangements on the integration of mental health across pharmacy practice. Such evidence will be essential to inform future strategies aimed at achieving genuine parity of esteem between mental and physical health care.

Funding

No funding was required for this work.

Conflicts of interest

None.

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Feasibility and acceptability of including depression in the community pharmacy NHS New Medicine Service: a pilot study

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Abstract

This evaluation examined the feasibility and acceptability of delivering antidepressant medication support through community pharmacy in England as part of the NHS New Medicine Service (NMS).

The pilot was run by NHS England between December 2022 and March 2024. The pilot evaluation, undertaken by NHS Arden and Greater East Midlands Commissioning Support Unit (Arden & GEM), was informed by a pipeline logic model and sought to support future rollout decisions. Thirty community pharmacies participated in the pilot, with 190 patients engaged. Sixty patients opted into the evaluation, of whom 12 participated in interviews and 16 completed surveys. Interviews with 20 community pharmacists (CPs) explored pilot delivery including training, confidence, safety and perceived value to patients. Wider implementation and safety considerations were captured through interviews with nine stakeholders, including general practitioners (GPs).

Patients reported the service to be highly acceptable, identifying the principal benefit as a healthcare professional 'checking in' with them during initiation of antidepressant medication. Most CPs perceived the service as beneficial to patients and reported increased confidence following training, although some felt training length was a barrier to participation. Initial concerns that consultations would be longer or more challenging than other NMS consultations were frequently alleviated with experience. GPs expressed mixed views warranting further investigation. No evidence of harm to patients was identified.

The evaluation informed NHS England's decision to ultimately include selected medications prescribed to treat depression within the NMS advanced service from October 2025. Limitations included self-selection and survivor bias, which may limit generalisability of findings.

Background

The NMS was first commissioned in 2011 and enables CPs to provide structured medication support to patients, and their carers, for a range of conditions. Patients and carers can discuss concerns or issues about their medication with the CP, who can then help them with problems linked to their medicine and promote lifestyle changes or other non-pharmacological interventions to enhance wellbeing. If needed, the CP can also refer the person back to their prescriber or signpost to further resources.

> **"The NMS is based on research[1] which has shown that pharmacists can successfully intervene when a medicine is newly prescribed, with repeated follow-up in the short term, to increase effective medicine taking for the treatment of a long-term condition."**

In December 2022, NHS England began to pilot an expanded NMS model for patients (≥18 years of age) newly prescribed antidepressant medication for depression.[2] The initial plan was for the pilot to be conducted in up to 100 sites with up to 40 patients per community pharmacy. The expansion proposed to provide patients with depression with

better support in managing their medicines regimen and adherence. This includes supporting patients to manage expected side effects, to understand the side effect profile of that medicine, and to understand that their medicines will take time to have an effect. The service is also intended to support patients in a person-centred manner, which complements and informs the shared decision-making process about taking a new medicine.

In 2024/25, 92.6 million antidepressant items were prescribed to 8.89 million identified patients in England.[3] Adherence to medicines prescribed for depression is reported to drop from 95.5 to 52.6 percent over an initial one-month period.[4]

The pilot was the first time a mental health condition had been considered for the NMS but was aligned with policy vision, wider support within the pharmacy sector and its representative bodies, and a growing evidence base including:

- The vision of the NHS Long Term Plan[5] to "make greater use of community pharmacists' skills and opportunities to engage patients"
- The vision set out in the Five Year Forward View for Mental Health[6] that "most [mental health] care should be provided in community and primary care settings"
- A Royal Pharmaceutical Society (now the Royal College of Pharmacy) report, in 2018, considering how pharmacy can support people with mental health problems, proposing a next step of including antidepressants in the NMS[7]
- An internal evidence review, commissioned by NHS England in 2021, which found reasonable quality evidence that pharmacist intervention "can be effective in promoting adherence in those taking antidepressants" in specialist settings but not specifically in community pharmacy
- A locally led pilot of an NMS-style intervention for depression in Devon[8]
- Studies showing that patients are willing to receive this type of support and CPs are motivated to deliver it[9] and pharmacist intervention can support adherence to antidepressant medication.[10]

NHS Arden & GEM was commissioned by NHS England in 2022 to conduct a formative evaluation of the NMS pilot for depression in community pharmacies.

The pilot

The standard NMS specification includes three stages: patient engagement, intervention and follow- up contact. For the depression pilot, a revised specification was followed which introduced a further optional stage of additional follow-up. The additional follow-up could take place up to five months after patient engagement to provide longer-term support and aid the shared decision on whether to continue the antidepressant.

To support delivery of the pilot service, CPs were required to complete training[11] and undertake a self-assessment designed to check their understanding

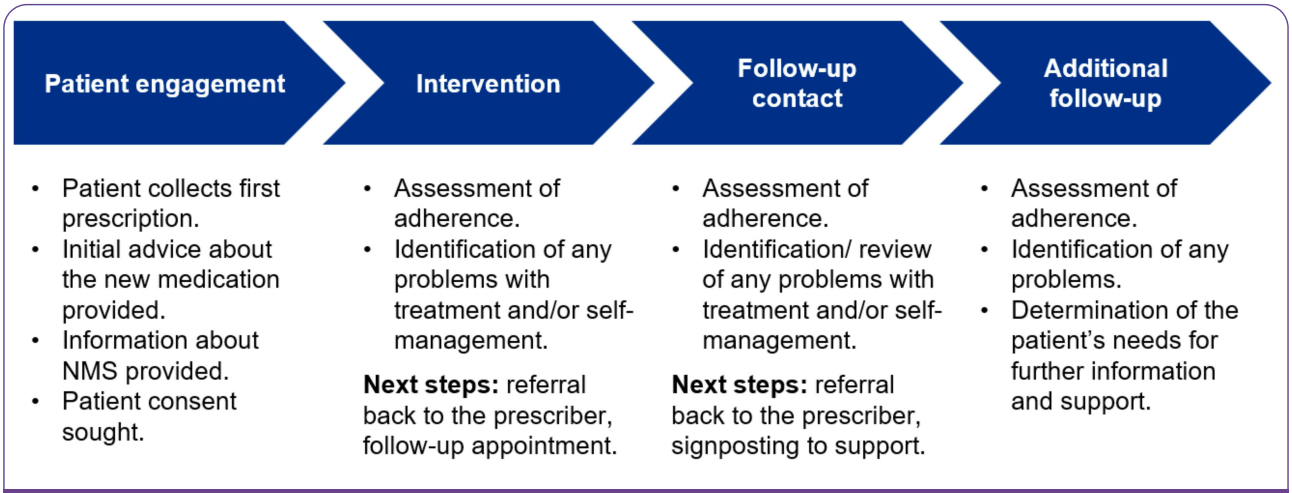
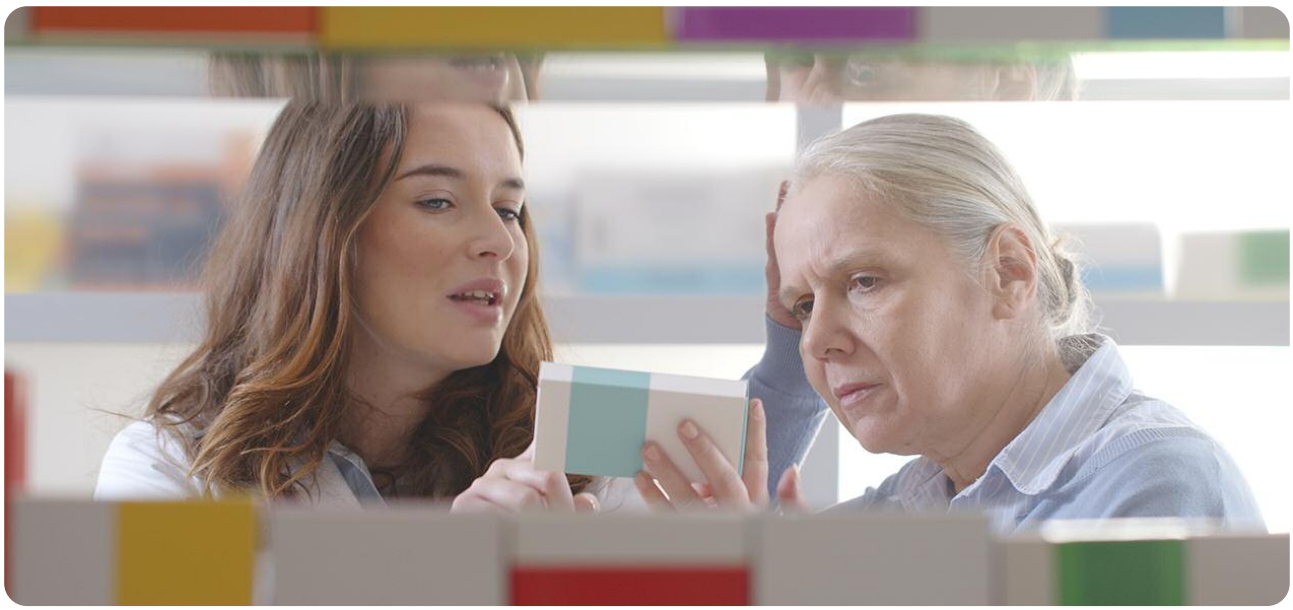


Figure 1: Summary of pilot NMS for depression model



and readiness to deliver it with confidence. The required training included:

- Centre for Pharmacy and Postgraduate Education (CPPE): Consulting with people with mental health problems (up to 120 mins)
- Royal College of Psychiatrists: Antidepressants (up to 90 mins)
- Royal College of Psychiatrists: Anxiety, panic and phobias (up to 60 mins)
- Zero Suicide Alliance (ZSA): Suicide Awareness Training (up to 20 mins)
- Scenario-based educational videos (up to 30 mins)
  - Disorganised thinking
  - Someone expressing loneliness
  - Uncertainty around antidepressants
  - Someone expressing anhedonia
  - When someone returns feeling worse.

A total of 74 (47%) of the 156 invited pharmacies took part in the pilot. Limited capacity among some pharmacies contributed to lower than anticipated activity levels. Of the 74 participating pharmacies, 30 (41%) sites had recorded having delivered activity when data collection for the evaluation ended on 30 September 2023.

The number of patients recorded as having engaged with the pilot was 190. Of these, 89 (47%) were recorded as completing the first follow-up stage and 15 (8%) completed the additional follow-up. There were 123 (65.4%) female patients, and 42.3% were between 18-34 years of age (the largest age group). Participating patients were predominantly White British (78.8%). Just over 50% of the pilot population were from the two most-deprived deciles of multiple deprivation (England). Most patient engagement with the pilot (63%) was registered in sites based in the East of England.

Region	Number of patients
East Midlands	119
Midlands	27
South West	21
North West	12
South East	11

Table 1: Number of patients engaged in the pilot by region

Sixty (32%) patients opted into the evaluation and provided valid contact details. The lower than anticipated uptake and delivery of the pilot impacted on the population opting into the evaluation.

Methods

The purpose of the evaluation was to inform future rollout decisions by understanding which aspects of the pilot were working well, which aspects were not working well, and if the training provided to CPs enabled the service to be provided safely and supported patient outcomes. The service's theory of change[12,13] was refined and used to inform decisions about the evaluation approach and to design data collection tools.

Participants

Patients

The evaluation explored the acceptability of the pilot NMS to patients, and their overall satisfaction with the service and its quality of care through two exit surveys and semi-structured interviews.

Survey links were delivered via SMS to patients with a valid mobile telephone number using the GOV.UK Notify service.[14] Survey data was collected using SNAP® (Snap Surveys©, 2023). The first survey (T1) went live from February 2023 with a response cut-off date of 30 September 2023. It was triggered when the CP provided the contact details for newly engaged patients to evaluators. Text messages were sent out, with the option to unsubscribe, and a reminder was sent to each recipient one week later. The second survey (T2) was sent to patients who had opted into the evaluation upon completion of the service; defined as patient reaching 'follow-up' or 'service exit'. These patients were identified in activity data recorded by CPs and provided weekly to evaluators via the NHS England Pharmacy Integration Fund (PhIF) team.

All available methods of contact (email, text message, telephone call) were used to invite patients to participate in an interview and text reminders were sent ahead of scheduled interviews. Where possible, messages were personalised and interview slots were offered up to 8pm on weekdays. A leaflet was provided by evaluators to all participating community pharmacies to support conversations with patients about the evaluation and encourage participation.

Community pharmacists

Using semi-structured interviews, the acceptability and feasibility of the pilot service model to CPs was explored along with their views on training, implementation, confidence in delivery and safety, and perceptions of value and benefits to patients.

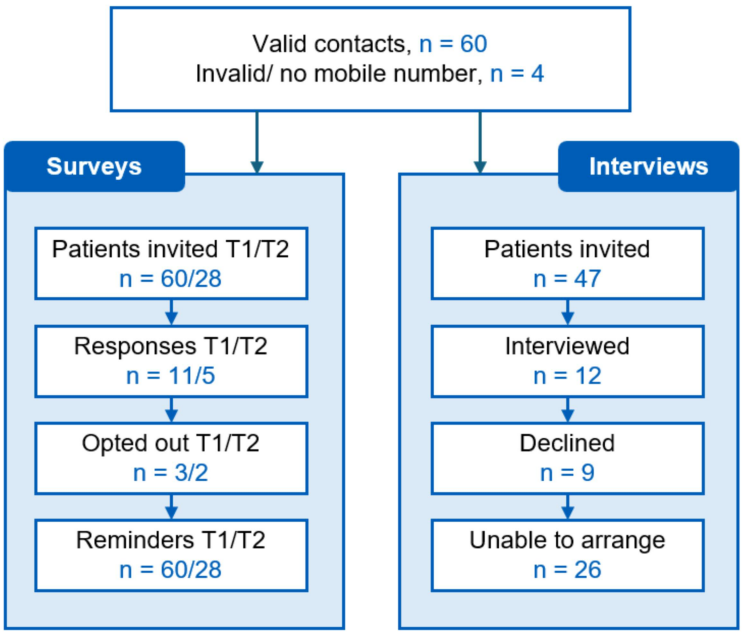
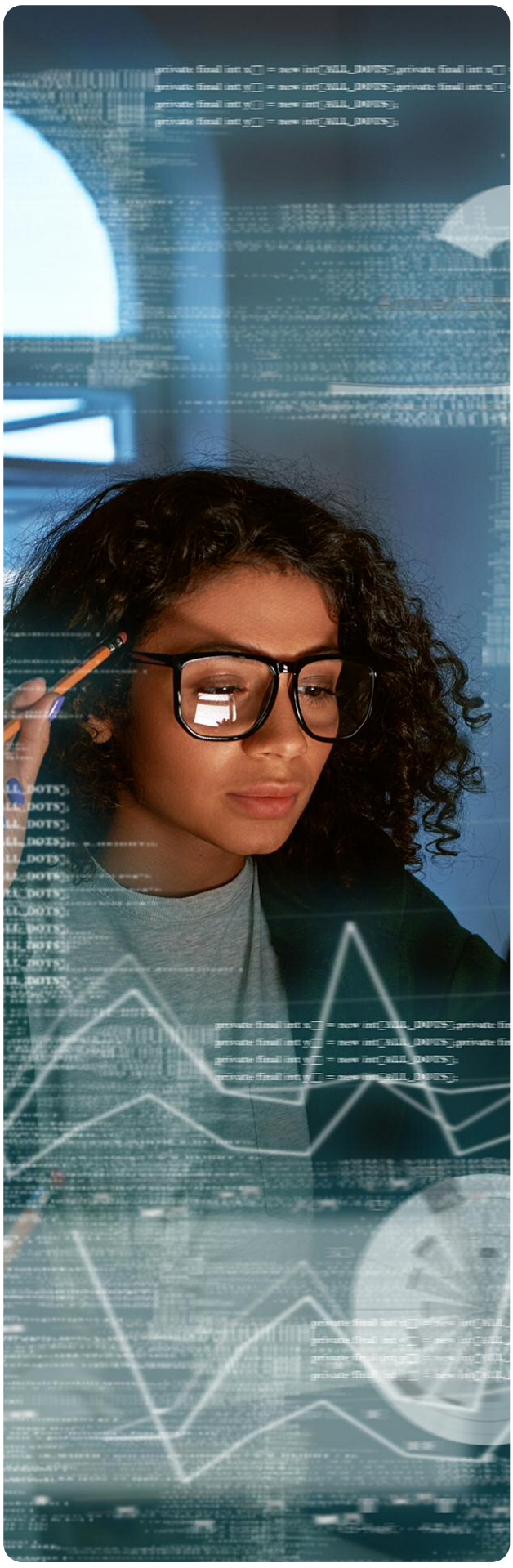


Figure 1: Patients' (opted-in) journey through the evaluation



Other primary care stakeholders

Using semi-structured interviews, the experiences and views of other stakeholders (including representative bodies, local/regional team members, pharmacy leads and GPs) were explored. Service activity data was collected by NHS England as part of contracting for the pilot. This data was used to explore the level of uptake to the pilot, for example, the number and type of pharmacies and the activity delivered.

Data analyses

Qualitative data from interviews with patients (n = 12), CPs (n = 20), GPs (n=4) and other stakeholders (n = 5) were recorded using software on encrypted NHS-issued devices. Repeat interviews were not conducted and participants did not review the transcript or summary of the interview. Interviews were transcribed verbatim unless the interview was not recorded; in which case notes were written up as soon as possible after the interview. A sample of interview transcripts was reviewed for quality.

"Transcripts were thematically coded, using relevant components of the logic model and allowing new themes to emerge organically from the analysis of the interviews. Interview data was analysed within and across cohorts (Table 2) considering the extent to which they converged or otherwise with dissenting voices actively sought."

Survey responses were low (T1 n=11; T2 n=5) and are presented descriptively. Service activity data was analysed descriptively.

Governance and oversight

Information governance was led by NHS England, with oversight from the PhIF programme delivery group and clinical reference group. Processes were established to ensure information governance, data protection and safeguarding requirements were met.

Theme	Patients	CPs	GPs	Other stakeholders
Acceptability	Confidence in the advice and support received during the intervention, and its suitability to support adherence and self-management.	• Mobilisation, set-up and delivery. • Staff motivation and capacity to deliver. • Patient willingness in practice.	Support for intervention.	Mobilisation and set-up (where applicable) and safety.
Feasibility	How and when the service was offered e.g. convenience, accessibility, suitability of location (e.g. private room).	• Delivery – records management, identification of eligible patients, completing additional follow-up, communication with referrers. • Suitability and availability of national/local information to support conversations and signposting to additional support.	Interaction with GP interventions.	Barriers to uptake.
Training	Not applicable.	• Acceptability and relevance of training received (e.g. duration, skills development). • Confidence to deliver the service and provide support to people with depression.	GP confidence in CP competence to deliver service.	Adaptations and delivery.
Support (staff)	Not applicable.	• Need for and availability (and/or suitability) of peer support. • Availability of other support.	Not applicable.	Provision of support/ facilitation of peer support networks.
Perceived benefits/ harms	Level of and type of information and support received in managing their medication.	• Perception of benefits/harms to patients. • Maintaining boundaries. • Views on risk of harm. • Availability of and confidence in routes of escalation.	Perception of benefits/ harms to patients.	Perception of benefits/ harms to patients.

Table 2: Interview themes by cohort

Results

A total of 60 (32%) patients opted into the evaluation and provided valid contact details between 16 December 2022 and 30 September 2023. Of the 60 patients invited to complete the Timepoint 1 survey, 11 (18.3%) responded during the evaluation window and of the 28 patients invited to complete the Timepoint 2 survey, 5 (17.9%) patients responded.

A total of 52 CPs were invited to interview. Of these 23 (44%) were from an 'active' site (actively delivering the service). Later sampling expanded to 'live not active' sites that had trained pharmacists but who were not yet delivering the service. In total 20 (38%) CPs were interviewed.

Patient acceptability and accessibility

Overall patients were positive about the service. They found it highly acceptable and described the main benefit as having someone 'checking in' on them. For some, contact appeared more significant than others. The familiarity that many patients had with their pharmacy/pharmacist and its accessibility and availability to them were also described as advantages.

"I do what they recommend first and then … I go back if it's not worked and they turn around and say like 'well try this'… and then if they say 'go to your GP' that's what I do because …it's what they've recommended ... I trust them ... I trust my pharmacy."

" … I have gotten more support and information from the pharmacist than I have my own GP. … You know, I feel like I don't wanna call or speak to my GP because you just get fobbed off or whatever. Whereas the pharmacist, I've had all of the support from them, you know, and all the information from them."

"It was having that extra someone checking on you, you know, making sure the medication was working, … did it need tweaking, with the times with the dates, …and just having that extra person just checking in and making sure you feel okay because I suppose with depression sometimes you feel there's not many people you can talk to about it."

Patient interview quotes

Patient adherence

Survey data, although limited, showed that most patients said they adhered to the medication as prescribed. Some evidence was found in interviews that contact with their CP improved adherence to medication.

"The first couple of weeks were really awful on the medication. I think if I hadn't been warned of that previous[ly] I would have been freaked out a little bit and thought 'oh gosh I shouldn't be taking these' and you know possibly have stopped, so yes it was really nice to have that told up front for me."

"She said it could … get worse at first, and obviously that sort of just put me off taking them because … what depressed person wants to get more depressed before they get better."

Patient interview quotes

Acceptability of training to CPs

Generally, CPs were satisfied with the training, which was well received and improved their confidence. Views differed on the length of training with some saying it was excessive and therefore a barrier to taking part. For others it was the right amount of training. Confidence, experience and capability, for example to maintain boundaries in conversations, varied across pharmacists and may explain why some pharmacists would like more training and some less. Some CPs found the scenario videos particularly helpful while others found them too specific to individual circumstances.

Where available, the inclusion of a local mental health professional in the training was valuable for understanding local services and providing support if needed.

" … my confidence [pre-training] was around 30 or 40 [out of 100]. … In the training, the case studies were very helpful, so it definitely improved so I would say after the training it was 70 or 80."

"Yeah, I think we struggled with the training a bit. It was very lengthy, probably a bit of information overload, but not really specific for the service."

"Patient skills training, which has got lots of scenarios. … the answers to the questions are so subjective that [they] are completely irrelevant to the situation you put yourself with the NMS … So I think that was a little bit of lacking in the training. … the training should be more focused on how to speak to the patient."

CP interview quotes

Perceptions of service delivery among CPs and GPs

CPs echoed patient findings with the majority saying it was of value and/or benefit to patients.

"The first couple of weeks were really awful on the medication. I think if I hadn't been warned of that previous[ly] I would have been freaked out a little bit and thought 'oh gosh I shouldn't be taking these' and you know possibly have stopped, so yes it was really nice to have that told up front for me."

"She said it could … get worse at first, and obviously that sort of just put me off taking them because … what depressed person wants to get more depressed before they get better."

CP interview quotes

Most (n=3) GPs were broadly supportive of patients having an extra source of support and focus on their medication which they felt would aid adherence. They also said those delivering the service should have training on suicide prevention and reinforcing to patients that their GPs provide medical review.

Two GPs were less supportive of the pilot service. One felt that primary care is becoming fragmented. They said that GPs should provide the support and questioned whether there was a gap in provision and it would duplicate the work of GPs. There was also a concern that it might generate additional work from community pharmacy.

" … my confidence [pre-training] was around 30 or 40 [out of 100]. … In the training, the case studies were very helpful, so it definitely improved so I would say after the training it was 70 or 80."

"Yeah, I think we struggled with the training a bit. It was very lengthy, probably a bit of information overload, but not really specific for the service."

"Patient skills training, which has got lots of scenarios. … the answers to the questions are so subjective that [they] are completely irrelevant to the situation you put yourself with the NMS … So I think that was a little bit of lacking in the training. … the training should be more focused on how to speak to the patient."

GP interview quotes

Some CPs expressed initial apprehensions that consultations would take longer than those for other NMS conditions and the conversations might be more challenging. These apprehensions were often alleviated in practice and with experience. Patients often would talk openly about the reasons for their depression; some staff were more comfortable with this than others.

Evaluators did not find any evidence of harms to patients or pharmacists during the evaluation. Potential areas of harm, including adverse impact on CP wellbeing, and mitigations were identified by all cohorts which could be considered as part of a wider rollout: whether to strengthen processes/ protocols for communication between CPs and GPs/prescribers, how to clarify and communicate responsibilities, including information given to patients about different professionals involved in their care.

Pilot uptake and delivery was lower than expected, raising questions about deliverability for wider rollout. The primary reason cited by pharmacy staff for non-participation in the pilot was lack of capacity – to be trained and deliver the service – especially where there were workforce issues. This may impact on community pharmacies as they consider what services they offer more broadly and where the value lies, both monetarily and to patients/customers.

"I think what we now need to … look at is when this becomes a national thing, is that how we're going to adapt this to our daily lives in the community pharmacy, and if the pharmacist is doing these consultations who is going to be helping out in the dispensary."

CP interview quotes

Limitations

The results are subject to self-selection and survivor bias as patients opted into both the pilot service and the evaluation. Therefore, this cohort may not represent the views and experiences of the eligible patient population who were either not offered or declined the service. The number of patients in the pilot was lower than expected. However, the target number of patient interviews (12) took place and there was a high degree of commonality across interview responses. The proportion of survey responses was lower than expected which limited the ability to give breadth to interview themes. The surveys were anonymous, so it is not possible to say whether those who responded at Timepoint 1 also completed the Timepoint 2 survey or took part in an interview.

Other cohorts (particularly CPs and GPs) are also subject to self-selection bias. There were challenges in engaging CPs and GPs in the evaluation. All CPs who had reported activity were initially contacted by evaluators. Later sampling included CPs who had been trained but had not started delivery. This enabled exploration of barriers to mobilisation and implementation. For some CPs, the evaluation interview occurred a considerable time after they had undertaken the training therefore their recollection of their training experience is at risk of recall bias.

"Despite multiple attempts and an expansion of the sampling area only two GPs directly connected to the pilot were interviewed. A further two GPs were interviewed about their general views on the pilot NMS."

Discussion and learning

The findings provided a greater understanding about delivery of the pilot NMS for depression and its acceptability and feasibility to CPs. It found the pilot NMS was acceptable to patients who said they felt supported by the contact offered. Patients otherwise may have either not sought support at all or accessed this support from their GP/practice (outside of routine medical reviews). There was some evidence that the support contributed to medication adherence.

The evaluation findings generated a number of considerations for NHS England when implementing a broader rollout:

Training and guidance for CPs

- Tailor training requirements to the needs of CPs through a combination of mandatory and optional training based on existing experience and skills.
- Promote different modes of training delivery (including group/locality-based) to support accessibility and the development of a community of local support.

- Encourage implementation leads to include local mental health professionals in training, as those CPs who received this as part of the pilot said it was extremely helpful.
- Ensure systems make existing local services, pathways and resources available to CPs, as part of their training, to support them to signpost patients where applicable.
- Develop tailored communications, informed by pharmacists experienced in delivering the pilot, to alleviate the initial apprehensions reported and highlight the importance of person-centred care, provision of healthy living advice and signposting in discussions about antidepressants.

Service information for patients

- Provide patients with information about the service that clearly explains its parameters and reminds patients about the roles and responsibilities of different professionals involved in their care and how to access this support.

Areas for further investigation

- Further investigate the views expressed by GPs that this patient cohort might find it harder to engage with the NMS or drop-out more frequently.
- Investigate whether outcome measures could be captured to help inform the extent to which the pilot service contributes to clinical outcomes and/or any future decisions about the broader community pharmacy offer/priorities.

The evaluation contributed to a broader programme of work that informed NHS England's decisions to expand the service to additional patient cohorts and whether to include support for depression within the NMS. NHS England continued to engage with subject matter experts and stakeholders, and ran the pilot until sufficient data were collected. Medications to treat depression were included in the NMS provided by community pharmacies from October 2025.[15] The additional follow-up was not included in the commissioned service as there was not enough evidence to warrant its inclusion.

Acknowledgements

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- We thank Marie-Louise Lawley at NHS Arden & GEM for editing support.

The views quoted are those of the interviewees and may not necessarily reflect those of NHS England, NHS Arden & GEM or other individuals and organisations who participated.

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SPEAKER

Beyond Training: Understanding the Hidden Barriers to Inclusion in Pharmacy Foundation Programmes

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Introduction: Why Inclusive Foundation Training Matters

Pharmacy foundation training plays a pivotal role in shaping professional identity, confidence and long-term career trajectories. It is intended to provide a supportive transition from university study to professional practice, enabling trainees to consolidate and apply clinical knowledge while developing as autonomous healthcare professionals. However, for many trainees, this period is marked by experiences of discrimination, exclusion or unequal treatment that undermine both learning and wellbeing.

Findings from an Equality, Diversity and Inclusion (EDI) Health Education England (HEE) Fellowship project[1] exploring lived experiences of pharmacy foundation trainees across the Southwest, Thames Valley and Wessex regions demonstrate that discrimination remains a significant and persistent issue. This article presents qualitative and quantitative findings that provide a window into the experiences of trainees.

The project used a structured survey to assess experiences of discrimination during the training programme. The Royal Pharmaceutical Society* (RPS) Race Microaggressions Toolkit served as a baseline to identify verbal and behavioural microaggressions in the workplace.

(*The Royal Pharmaceutical Society officially became the Royal College of Pharmacy on 15 April 2026. Royal College of Pharmacy and RPS are used throughout.)

> *Microaggressions are subtle comments or behaviours, often unintended, that convey bias, stereotypes or exclusion towards individuals because of aspects of their identity. Such experiences may appear minor in isolation but can accumulate over time, affecting wellbeing, confidence and a sense of belonging.*
>
> Royal College of Pharmacy
> Race microaggressions document
>
> https://www.rcpharm.org/inclusion-and-diversity/microaggressions/

Understanding Trainee Experiences of Discrimination

The project was undertaken as a service evaluation and included appropriate participant support measures due to the sensitive nature of exploring lived experiences of discrimination.

Survey Findings

In total, 37 responses were received, of which 28 met the inclusion criteria.

Quotations throughout this article are reproduced directly from survey participants.

Participants were asked whether they believed they had experienced discrimination during training and reflected on experiences from a predefined list of microaggressions based on the RCP toolkit.[2,3]

Quantitative Insights: Microaggressions in Everyday Practice

- **The most frequent verbal microaggressions included:** *"Where are you from?", "No, where are you really from?", "Where were you born?", and "When is the last time you went home?"* (13 out of 15 options were selected).
- **Common behavioural microaggressions included:** *Mispronouncing or misspelling names, being ignored or excluded in the workplace, and excessive scrutiny or harsher judgment.* (9 out of 10 options were selected; physical abuse was not reported).

"47% of respondents reported experiencing discrimination in the workplace during their foundation year."

These experiences were rarely overt. Instead, trainees described subtle, persistent behaviours - microaggressions - that altered how they were treated compared with colleagues.

"Colleagues tend to act overly cautious or feel the need to ask questions about my background which still singles me out and is not their natural way of communicating with my white counterparts."

"When are you going back home?" - referring to this as my only option after completing my training year.

Identity, Belonging and Intersectionality

Discrimination was often experienced in an intersectional way. Trainees described how ethnicity intersected with religion, culture and personal identity, particularly where assumptions were made about beliefs or practices.

"I felt forced to celebrate something I didn't want to celebrate because I don't believe in it."

"I felt excluded due to different culture to everyone."

The Hidden Impact on Wellbeing and Learning

The implications of discrimination during foundation training extend well beyond individual discomfort. Fellowship data indicate that experiences of discrimination are associated with anxiety, reduced confidence and disengagement from learning opportunities.

Emotional Impact

"Mental health went down when I started pre reg."

Pressure to Prove Yourself

Several trainees described the emotional and cognitive burden of constantly feeling scrutinised or needing to prove themselves.

"I feel I always have to work extra hard (more than my other colleagues) to prove myself. I don't always feel like I can raise complaints like my white counterparts because this may be perceived as 'nagging'."

Another respondent reflected:

"Being from ethnic minority you are expected to work harder and perform above par from others."

These pressures can have tangible consequences.

"I do not feel 'welcome' and take any chance I get to be off work. I feel very anxious relating with senior white colleagues because I either feel the need to go an extra mile to prove myself to them, or am almost always expecting them to question me on my background instead of addressing my learning needs."

Fellowship findings also highlighted wider impacts on wellbeing and support. ***Only 23% of respondents felt their wellbeing was fully supported during the training programme, while 75% highlighted a lack of culturally appropriate wellbeing services.***

Assumptions About Identity and Competence

Discrimination was rarely a single event. Trainees described cumulative experiences that reinforced feelings of othering.

"Colleague was shocked at how good my English was after asking -Where are you from?"

"Being confused with someone of the same race as me."

"I was mistaken for other colleagues who are considered South Asian. This became increasingly frustrating as people could not distinguish me from other people."

If discrimination during training is not addressed, the profession risks normalising inequity early in pharmacists' careers, with long-term consequences for workforce retention, leadership diversity and patient care. Conversely, if a meaningfully equitable experience can be provided, this will foster a platform for all trainees to have the best start to their professional development and future career.

While the General Pharmaceutical Council (GPhC) standards for initial education and training emphasise fairness, equality and learner support, these findings suggest a gap between policy intent and lived experience, particularly during a time-limited, high-stakes training year.[4]

Speaking Up: Barriers to Raising Concerns

Structural factors also played a significant role. Nearly 40% of respondents reported that they did not know where to go for help or did not feel confident about raising concerns, despite many indicating that they felt informal support from colleagues existed.

This gap between perceived interpersonal support and confidence in formal processes reflects a broader systemic issue. Limited diversity in senior leadership, inconsistent supervisor capability in cultural competence, and unclear reporting pathways all contributed to reluctance to escalate concerns.

Fear of Raising Concerns

"As a trainee, you do not know who to talk to."

"I had spoken to other colleagues about this but did not feel that any action would be taken or that my report would be taken seriously."

"I am vaguely aware of the process... it is not clear/easy to use."

"Fear of a negative blow back. Fear of claims it may not be because of race but other issues."

Concerns were not limited to staff experience. Trainees also reported witnessing discriminatory behaviours.

"I have noticed patients being treated less favourably. Although not overtly racist, I have noticed upsetting covert discrimination."

Leadership, Representation and Psychological Safety

Concerns about being misunderstood or dismissed were particularly prominent where leadership lacked visible diversity.

"I guess if there's no diversity in the management team they wouldn't understand the weight of such issues."

"With majority of management being white, it is not particularly easy to raise concern on issues like this as there is fear of not being understood."

Representation Matters

"I do not feel comfortable with the fact that there is no one who looks like me on the training team and this contributes to feeling uncomfortable expressing myself to colleagues or management."

"I am the only Asian in my department."

These patterns align with early findings from NHS England's Pharmacy Workforce Race Equality Standard (Pharmacy WRES), which highlight disparities in staff experience, confidence in speaking up and perceptions of fairness across the pharmacy workforce.[5]

Support Systems: What Helped Trainees

Trainees consistently emphasised the value of support and understanding.

> *"Just speaking with other peers was helpful. I did later have a tutor who was extremely supportive."*

They also highlighted the need for broader education.

> *"Education on different cultures and impact on daily life."*

> *"Although inclusivity training is mandatory at the start of employment at the Trust, there seems to be a lot of ignorance around the topic in practice."*

When Concerns Were Addressed Well

One trainee described a positive experience of raising concerns, where they felt their report was taken seriously and appropriate action was taken.

> *"I reported it and it was dealt with appropriately and fairly. I told my education lead/manager who dealt with it really well - she told the EDI representative, then talked to the pharmacist that made the comments. Nothing has happened since."*

What Needs to Change

While individual acts of discrimination can occur at interpersonal level, the fellowship findings suggest that sustainable change requires action across organisational culture, leadership, education and supervision. Based on fellowship findings, several priority actions were identified:

Promoting inclusion and belonging:

- Active bystander and allyship training for all staff involved in training
- Embedding cultural competence and inclusive supervision skills into tutor and supervisor development

Strengthening leadership and representation:

- Increasing ethnic minority representation in senior leadership
- Ensuring diversity among those delivering education and training programmes

Improving education and curriculum:

- Decolonising the pharmacy curriculum to better reflect diverse histories, perspectives and patient populations

Assuring training quality:

- Strengthening quality assurance of training placements, including trainee experience as a core metric

Making it safer to raise concerns:

- Clarifying and simplifying reporting processes, including comprehensive information on how to raise concerns, during induction to the training programme.
- Reinforcing psychological safety and protection from retaliation
- Considering how trainees in a small organisation (where, for example, their supervisor is also their direct employer) can effectively raise concerns

Respondents also highlighted the importance of collective ownership, with **54% identifying a greater shared responsibility for addressing racism as a priority for change,** alongside ethnic minority staff networks and improved representation in leadership.

Embedding Change Across Education and Practice

The findings of this project and a range of recommended actions were shared broadly within NHS England, both in the South West and nationally.

This supported HEE (now NHS England Workforce Training and Education) in the development and implementation of a range of interventions to address inequity in trainee experience. These initiatives can help operationalise inclusion when implemented consistently and meaningfully. In the Southwest region, this included feeding into the development of the Southwest Inclusive Pharmacy Practice Manifesto.[6] The SW IPP Manifesto drew on the concepts of the joint national plan for Inclusive Pharmacy Practice (IPP) (March 2021) and built upon this to create a manifesto of five core themes (one of which is focussed on Education and Training) that set out statements of intent for how inclusive practice can be meaningfully implemented.

Inclusive Communication in Practice

Many microaggressions described by trainees reflected unintended behaviours rather than overt hostility. Inclusive practice does not require avoiding conversations about identity or culture; rather, it involves approaching them with awareness, respect and openness.

Instead of...	Consider...	Why it matters
"Where are you really from?	"Would you be comfortable sharing more about your background?"	Avoids implying someone does not belong locally or professionally
Avoiding someone's name because you are unsure how to pronounce it	Politely asking: "Could you help me pronounce your name correctly?"	Demonstrates respect and willingness to learn
Assuming beliefs, religion or cultural practices	Allowing individuals to share what is important to them	Reduces stereotyping and assumptions
Becoming defensive when concerns are raised	Listening openly and reflecting on impact	Helps create psychological safety and trust
Treating inclusion as avoiding difference	Creating environments where people feel valued without being singled out	Supports belonging rather than "othering"

Intent and impact are not always the same.
Many microaggressions are unintended, but repeated experiences can still affect confidence, wellbeing and sense of belonging. Inclusive practice requires ongoing reflection, curiosity and respectful dialogue across pharmacy teams.

More broadly, NHSE's joint work with the RCP, APTUK and others on Inclusive Pharmacy Practice reinforces the importance of everyday behaviours, cultural competence and psychologically safe learning environments.[7] These principles align closely with fellowship recommendations and offer a shared language for inclusion across education providers and employers. Another key NHSE initiative is The Safe Learning Environment Charter.[8] Originally developed in the Southwest region in the context of midwifery learners, this was embraced by pharmacy as it was pivoted to multi-professional application. It now forms a key touchpoint for inclusive practice for learners in the Southwest and across England. The Safe Learning Environment Charter further strengthens inclusive practice by setting expectations for respectful behaviour, accountability and learner protection. When used as an active quality assurance tool - rather than a symbolic commitment - it has the potential to make training environments safer and more consistent for all trainees.

Also, the NHSE Trainee Support Guide provides a clear framework for how trainees can access pastoral, educational and wellbeing support.[9] Fellowship findings suggest that greater visibility and proactive use of this guide - embedded into induction, supervision and placement quality assurance - could address the confidence gap many trainees experience when raising concerns.

Moving from Awareness to Action

The fellowship survey also highlighted a shift in understanding around microaggressions as participants progressed through the questions. Approximately 80% of respondents initially reported not having experienced microaggressions, but this figure fell to around 50% after they engaged with professional themes and lived-experience examples. This demonstrates that education is a key tool for recognition and empowerment - an approach already adopted within some training programmes.[10]

Inclusive training environments are shaped daily by pharmacy teams. Pharmacists, supervisors and leaders influence how safe trainees feel to ask questions, make mistakes and raise concerns.

> *"Empathy is not relating to an experience; it's connecting to what someone is feeling about an experience."* —
> Brené Brown, Atlas of the Heart

Conclusion: Creating an Environment Where Everyone Can Succeed

Discrimination during pharmacy foundation training - in all its forms - undermines learning, wellbeing and workforce sustainability. Fellowship findings show that while many trainees value informal support, too many experience exclusion and lack confidence in formal systems.

Embedding inclusion into leadership, supervision, education and quality assurance - supported by NHSE initiatives such as the Trainee Support Guide, Inclusive Pharmacy Practice and the Safe Learning Environment Charter - is essential if pharmacy is to retain and develop a diverse workforce capable of meeting patient needs.

An inclusive profession is not defined by who enters it, but by who is enabled to succeed.

The authors recognise that some of the lived experiences shared in this article may be difficult to read. Quotations have been reproduced as written by participants to preserve authenticity and transparency.

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Building Trauma-Informed Teams: From Policy to Practice in Pharmacy Settings

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About the author

Rachael Lemon is founder of Lemon Aid Coaching & Consulting, specialising in trauma- informed, neuroinclusive leadership for healthcare professionals. An Honorary Member of the Royal College of Pharmacy for distinguished services to pharmacy, her 20+ years of NHS leadership includes the English Pharmacy Board and strategic advisory roles across NHS England, Department of Health, and Royal Colleges. A domestic abuse survivor with specialist training in trauma-informed practice and rape crisis work, she brings both lived and professional expertise to her coaching practice.

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In 2020, NHS England mandated that all trusts implement domestic abuse workplace policies.

Six years later, ask most pharmacy professionals if their workplace has a domestic abuse policy. They'll say either "I don't know" or "Probably, but I've never seen it."

Ask HR where it lives. They'll send you a 47-page document buried in the intranet under "Staff Wellbeing Policies (Archived)."

This is the pattern with trauma-informed policies: Policy created (often excellent, comprehensive, evidence-based). Policy uploaded to intranet. Nobody trained on implementation. Staff don't know it exists. Management references it when questioned but doesn't enforce it. Nothing changes.

The policy exists. The practice doesn't.

What PIE Actually Means

PIE - Psychologically-Informed Environments - emerged from homelessness services. The recognition that physical safety isn't enough. That people need psychological safety to heal, grow, and function.

The framework has since spread to mental health services, substance misuse treatment, and domestic abuse support - anywhere trauma is prevalent.

> **"PIE in theory: Understanding how trauma affects behaviour, designing environments and interactions that support psychological safety, training staff in trauma responses, building supportive cultures."**

PIE in practice: Everything from where you put the chairs in your consultation room to who has access to staff support, from how you respond to mistakes to whether managers ask "what's wrong?" or "what happened?"

Is Your Pharmacy Trauma-Informed or Trauma-Aware?

Before building trauma-informed teams, you need to know where you're starting.

Physical Environment

Trauma-aware has consultation rooms. Trauma-informed has consultation rooms designed for

psychological safety - door with window (privacy plus visibility), lockable from inside, panic button accessible, comfortable seating arranged so nobody has their back to the door, tissues readily available, water within reach.

"Trauma-aware acknowledges staff need breaks. Trauma-informed has designated quiet space where staff can regulate after difficult interactions, somewhere private where crying is okay, where neurodivergent staff can decompress from sensory overload."

Trauma-aware displays support helpline posters. Trauma-informed makes helpline info accessible without being performative, materials in multiple languages, considers what barriers (cost, accessibility, immigration status) might prevent use.

Staff Support

Trauma-aware has an Employee Assistance Programme. Trauma-informed recognises EAP limitations (typically 6 sessions, phone-based, generic counsellors with no healthcare context), provides access to specialist trauma counselling, acknowledges that trauma recovery takes longer than six weeks.

Trauma-aware offers mental health first aider training. Trauma-informed ensures mental health first aiders have protected time, ongoing supervision, clear boundaries about what they can and can't do, access to clinical support when needed, recognition that this role carries vicarious trauma risk.

Trauma-aware encourages staff to "be resilient." Trauma-informed builds organisational resilience through adequate staffing, manageable workloads, psychological safety to raise concerns, systems that support rather than blame.

Management Practices

Trauma-aware has diversity and inclusion policies. Trauma-informed understands intersectionality - that Black women face different workplace trauma than white women, that disabled professionals face

different barriers than able-bodied professionals, that immigrant workers face different vulnerabilities than citizens.

Trauma-aware documents performance concerns. Trauma-informed asks "what changed?" before documenting, explores whether trauma responses are being misread as capability issues, considers reasonable adjustments.

Trauma-aware has a bullying and harassment policy. Trauma-informed believes people the first time they report, protects reporters from retaliation, holds perpetrators accountable regardless of their position, recognises that toxic leadership creates organisational trauma.

Building From the Ground Up

If your assessment revealed you're trauma-aware but not trauma-informed, here's where to start.

Leadership Commitment (Without This, Stop Here)

Trauma-informed culture requires leadership commitment. Not policy approval. Actual commitment.

Leaders acknowledge workplace trauma exists in their organisation. Resources are allocated (time, money, training, specialist support). Accountability structures for toxic leadership. Willingness to change systems, not just individuals. Understanding this is ongoing work, not a one-time project.

Without this, you'll build trauma-informed policies that nobody implements.

Staff Education

The distinction matters. Training teaches "here's what to do when someone discloses trauma." Education teaches how trauma works, how it shows up, how it affects everyone differently, what your own trauma responses might be, why psychological safety matters, how systems perpetuate harm.

Education comes first. Skills training follows.

Start with how trauma affects the brain and body, common trauma responses (fight, flight, freeze, fawn, flop), intersectionality and how different identities face different traumas, neurodivergence and trauma intersection, your own trauma responses and triggers, organisational trauma and toxic systems.

Then move to skills: holding disclosure without fixing, setting boundaries, recognising when you're triggered, accessing support, building referral pathways.

Environmental Design

Walk through your pharmacy with trauma-informed eyes.

> **"Consultation spaces: Can someone disclose safely here? Is there privacy? Can they see the exit? Is there somewhere to sit that doesn't feel like an interrogation? Can you offer water? Are there tissues? Is the space culturally appropriate?"**

Staff spaces:
Where do staff go when triggered? After holding a difficult disclosure? When experiencing sensory overload? When they need to cry? When they need silence?

Accessibility:
Can wheelchair users access consultation spaces? Are materials available in large print? Are visual cues available for neurodivergent staff? Is there somewhere low- sensory for those who need it?

Safety:
Panic buttons? Lone working protocols? Clear sight lines? Lockable doors that open from inside?

Practice Changes

This is where policy becomes practice.

When is it appropriate to ask about trauma? How

do you hold the answer? What support do you need before asking? What happens after disclosure? Where do you refer? How do you document safely? Who do you debrief with?

"When someone's performance declines: What changed in this person's circumstances? Could this be a trauma response? What support might help? What adjustments could we make? How do we hold accountability with compassion?"

In team meetings: How are you really? What's challenging right now? What support do you need? Who's struggling? What systemic issues are we seeing?

Ongoing Support Infrastructure

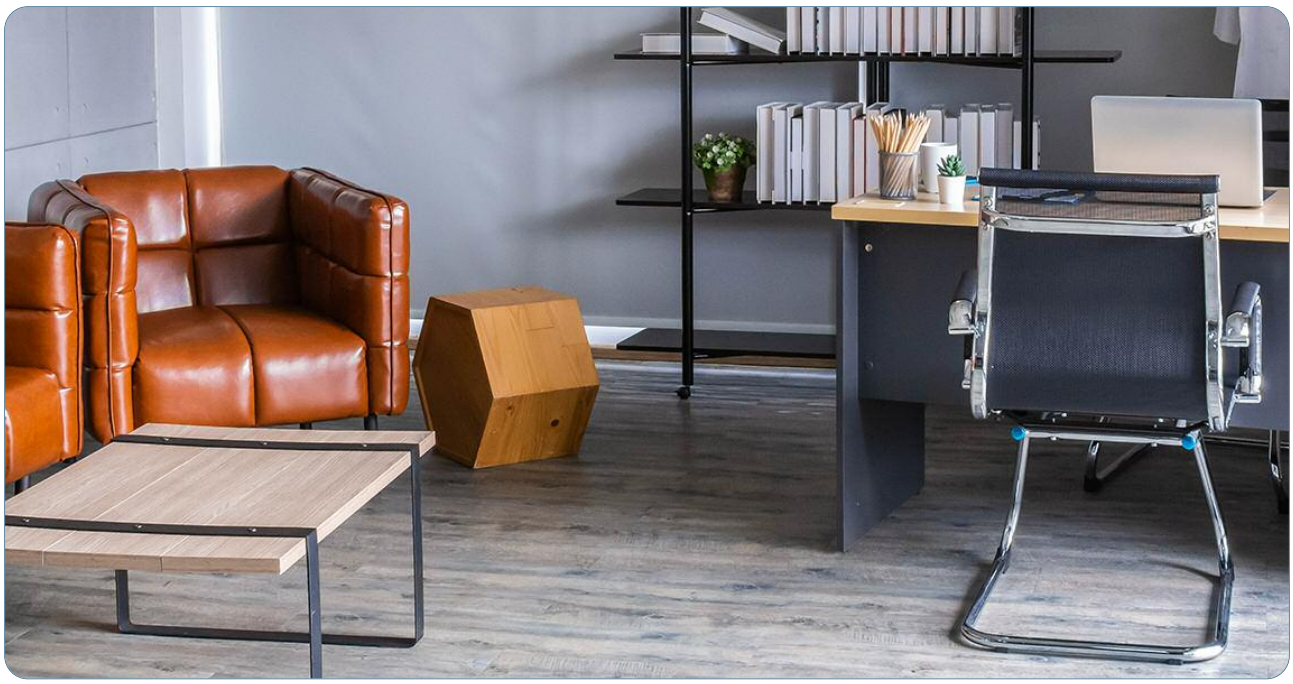
This is continuous practice, not a one-time destination.

Regular supervision for staff holding trauma (not annual appraisals - actual clinical supervision). Debriefing spaces after difficult interactions. Peer support networks where staff can share without judgement. Access to specialist support (not generic EAP - trauma specialists who understand healthcare contexts). Protected time for wellbeing (not "fit it in when you can").

The Pharmacy-Specific Challenges

Community pharmacy isolation presents unique barriers: often the sole qualified person in building, no immediate colleagues to debrief with, public-facing all day with no psychological safety net, limited private space, commercial pressures conflicting with professional duties.

Trauma-informed approaches include regional peer support networks (pharmacists supporting pharmacists), access to remote supervision and debriefing, clear escalation protocols for difficult situations, protected time for professional support built into contracts, not "if you can manage it."



Hospital pharmacy hierarchies face different challenges: rigid hierarchies that silence junior staff, toxic leadership disguised as "strong management," restructuring that removes support whilst increasing demands, professional isolation within teams (pharmacy viewed as "support service" rather than clinical equals).

Trauma-informed approaches include psychological safety for junior staff to raise concerns, accountability for leadership behaviour, recognition that pharmacy staff carry clinical responsibility and emotional labour, integration into clinical teams rather than isolation.

What Doesn't Work (And Why We Keep Doing It)

One-off training sessions don't create trauma-informed teams. They create staff who know trauma exists and feel overwhelmed by the gap between awareness and capability.

Policies without enforcement are worse than having no policy. Having a domestic abuse policy nobody knows about and management doesn't enforce creates a false sense of safety.

Mental health first aiders are valuable but not sufficient. Expecting one person with 2-day training to handle organisational trauma without ongoing supervision, protected time, or specialist backup is dangerous.

"Resilience training for staff doesn't work. Teaching individuals to be more resilient in traumatising systems pathologises normal responses to abnormal situations. Individual resilience isn't the problem, organisational trauma is."

"Wellness" initiatives without systemic change are performative. Yoga classes and fruit bowls don't fix toxic leadership, impossible workloads, or discriminatory systems.

What Actually Works: A Case Study

Respecting confidentiality, I'll share the framework from an organisation I consulted with. The specifics don't matter. The approach does.

A healthcare department. Significant retention issues. Staff leaving, particularly those from minoritised backgrounds. Exit interviews revealed patterns: feeling unsupported, experiencing microaggressions, facing barriers to progression, workplace trauma unaddressed.

The traditional response would be a diversity training module, revised policies on paper, and perhaps the appointment of a wellbeing officer.

They took a different approach.

Leadership acknowledged reality. Not "we value diversity" statements. Actual acknowledgement: "Workplace trauma exists in our department. We've failed staff. We're committing to change." No defensiveness. No "but we're good people." Just the truth.

Trauma education for all staff. Six monthly sessions. Not "here's what to do when..." but "here's how trauma works, how it affects people differently, what your own responses might be, why systems perpetuate harm." Brought in trauma specialists with lived experience. Paid them properly.

Environmental redesign. The break room became an actual sanctuary. Comfortable seating. Low lighting option. Sound-dampening. Private corner where crying is okay. Consultation rooms redesigned for psychological safety. Chairs are arranged so nobody has their back to the door. Panic buttons accessible. Tissues within reach.

Regular wellbeing check-ins. Weekly team meetings. Not performance reviews. Actual "how are you?" The manager is trained to notice changes and ask compassionate questions before documenting concerns.

Peer support network with protected time. Not "fit it in when you can." Actual allocated time. Structured debriefing protocols. Access to supervision.

Specialist trauma counselling access. Partnered with external trauma service. Not generic EAP offering 6 sessions. Actual specialist support with no arbitrary limits.

Performance management overhaul. When performance changed: exploration before documentation. "What happened?" before "what's wrong with you?" Reasonable adjustments proactively offered. Support provided before capability proceedings considered.

Accountability for toxic leadership. This is where most organisations fail. They held a toxic manager accountable. Didn't move them sideways. Didn't promote them elsewhere. Didn't protect them because they "get results." Actually addressed the harm they'd caused.

Within 18 months: Staff retention improved, particularly among those from minoritised backgrounds who'd been leaving at highest rates. Sick day patterns shifted - not because people were healthier, but because they felt safe disclosing

problems and getting support before the crisis. Performance outcomes improved - because staff getting trauma support performed better than staff being performance-managed for trauma responses. Culture transformed - staff described feeling "actually seen" rather than "diversity box-ticked." Patient care improved - less burnt-out and better-supported staff provided better care.

The cost was significant. Upfront investment. Ongoing commitment to protected time for wellbeing activities, specialist support contracts, regular training and education, environmental improvements, leadership capacity to address toxic behaviour.

From a pure business perspective: trauma-informed investment paid for itself. Reduced recruitment costs (retention improved). Reduced agency staff costs (fewer gaps to fill). Reduced sick pay costs (earlier intervention prevented crisis). Improved performance indicators. Better staff survey results. Lower complaint rates.

From a human perspective: staff stopped quietly suffering. Some stayed who would have left. Some disclosed trauma they'd been carrying alone. Some got support that changed their lives.

This worked because they acknowledged the problem existed, committed resources, centred lived experience, changed systems not just individuals, held everyone accountable (including leadership), sustained the work beyond initial enthusiasm.

This wasn't about one charismatic leader or lucky timing. It was about organisational commitment to trauma-informed practice as ongoing work, not one-time project.

Starting Where You Are

You might not have a budget for specialist consultants. You might not have leadership buy-in. You might be one person trying to make a difference.

Start anyway.

What one person can do: Ask "What changed?" instead of documenting performance concerns. Create psychological safety in your own interactions. Believe people the first time they tell you something's wrong. Advocate for trauma-informed approaches. Connect with peers facing similar challenges. Build knowledge through free resources. Take care of your own trauma responses.

What small teams can do: Regular check-ins focused on wellbeing. Peer support networks. Environmental changes within your control (rearranging furniture, creating a quiet corner, improving signage). Advocacy to leadership with evidence of need.

What organisations can do: Everything outlined above. With commitment, resources, and accountability.

Your Position to Lead

You're positioned to build trauma-informed teams because you understand the systems from inside. You know what pharmacy professionals actually face.

> **"Every gap in current practice is an innovation opportunity. Every policy that exists without implementation is a transformation waiting to happen."**

Building trauma-informed teams isn't quick. It isn't simple. It requires sustained commitment, resources, cultural change, and accountability.

But it's possible. And it's necessary.

Because you cannot ask pharmacy professionals to hold other people's trauma whilst working in traumatising environments.

You cannot build trauma-informed patient care without trauma-informed workplace culture. You cannot create psychological safety for some whilst denying it to others.

Start with one conversation. One environmental change. One compassionate question. Ask someone on your team: "How are you really?"

And stay to hear the answer.

Practical Resources

Free Training & Education:

- NHS Education for Scotland (NES) TURAS - https://learn.nes.nhs.scot
- NHS eLearning for Healthcare - https://www.e-lfh.org.uk
- SAMHSA Trauma-Informed Approach - https://www.traumainformedcare.chcs.org/resource/samhsas-concept-of-trauma-and-guidance-for-a-trauma-informed-approach/
- CELCIS (PIE resources) - https://www.celcis.org

Specialist Organisations:

- Rape Crisis England & Wales - https://rapecrisis.org.uk
- SafeLives - https://safelives.org.uk
- Mind (Workplace wellbeing) - https://www.mind.org.uk/workplace
- ACAS (Trauma-informed / domestic abuse workplace guidance) - https://www.acas.org.uk/health-safety-and-wellbeing-when-working-from-home/domestic-violence-and-abuse

Professional Support:

- NHS Practitioner Health - https://practitionerhealth.nhs.uk
- Pharmacist Support - https://www.pharmacistsupport.org (specialist support for pharmacists)

A couple of notes:

- ACAS doesn't have a single page titled "trauma-informed workplace guidance" but its self explanatory to navigate
- CELCIS's specific PIE resources sit within their broader site rather than a dedicated PIE landing page, so I've given the main site - again self explanatory to navigate and deep dive for those interested

Discussion Points For Your Team

- Where does your workplace fall on the trauma-aware to trauma-informed spectrum?
- What's one environmental change you could make this week?
- Who on your team carries vicarious trauma and what support do they have?
- What barriers prevent trauma-informed practice in your setting?
- What would psychological safety look like for your team?

Next Issue of PM Healthcare Journal:

- Leading Through Trauma – Intersectionality, equity versus equality, and building survivor-led solutions in pharmacy leadership.

Previous Articles for PM Healthcare Journal

- The Professional's Blind Spot (Winter 2026, Issue 15)
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